

# NAVY MEDICINE

January-February 2004

*Report from Liberia*



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**COVER:** Samuel K. Doe stadium in Monrovia serves as a medical treatment facility while Liberia begins recovering from a long civil war. Story on page 5. Photo by CDR Eugene F. Smallwood, MSC, USN.

# Georgia Clinic Dedicated to a Man of “Common Virtue, Called to Duty”

Loren Barnes

A new \$6 million Branch Medical and Dental Clinic at Marine Corps Logistics Base Albany, GA, was dedicated in the name of Pharmacist's Mate Second Class John Henry Bradley on 31 October 2003.

Bradley is famous for his participation in the 23 February 1945 flag raising at Mt. Surabachi on Iwo Jima during World War II. The event was immortalized in a photo by Joe Rosenthal and later in the famous Marine Corps War Memorial in Arlington, VA. He was the only Sailor raising the flag alongside five Marines. Bradley was selected for the hospital dedication because he epitomizes the Navy–Marine Corps team.

RADM Robert D. Hufstader, Medical Officer of the Marine Corps, was the guest speaker at the opening ceremony. In his remarks, Hufstader said, “That partnership makes the sea services far more powerful in the nation’s service together than they would be separately . . . The flag raising—five Marines, one Sailor, an American flag on a pipe, on a war-torn hill, on a little island nobody had



Members of Pharmacist's Mate Second Class John Henry Bradley's family view a shadow box filled with medals, citations, and historical documents relating to PhM2c Bradley's exemplary Navy career. The display will be exhibited in the entry area of the new Branch Medical and Dental Clinic.

ever heard of, on the far side of the world—illustrates better than any words, the Navy–Marine Corps partnership and its power.”

Bradley's son James perhaps best described his late father and others who fought in World War II, and particularly at Iwo Jima, in his book *Flags*

*of Our Fathers*. Bradley wrote, “They were boys of common virtue, called to duty, brothers and sons, friends and neighbors, and fathers. And it's as simple as that.”

“It really is as simple as that,” Hufstader said. “Our nation has simply been blessed with people of com-

mon virtue that became uncommon valor.” Hufstader said the Navy Hospital Corps has had more of its fair share of such people from the Revolutionary days of the “Loblolly Boys” to the pharmacist’s mates of the two world wars to today’s hospital corpsmen serving in Iraq. He pointed out that “This doesn’t happen by accident. We nurture it and we grow it.”

Bradley’s wife Betty, who traveled from Wisconsin with her children and grandchildren for the ceremony, noted that her husband was very humble and that if he were alive today wouldn’t have attended the event. She said, “He had wonderful excuses. But for us it’s a great honor.” She was pleased that Hufstader mentioned to the grandchildren that they should bring their children here in later years to see this.

The admiral also pointed out that as a corpsman her husband did more heroic things than just raise the flag. Assigned to the 28th Marines of the 5th Marine Division, Iwo Jima was Bradley’s first and only campaign, a horrific battle in which every 2 minutes for 36 days a Marine was killed or wounded. Bradley landed with the regiment on 19 February 1945, and just 2 days later earned the nation’s second highest award, the Navy Cross.”

Before climbing Mt. Surabachi, Bradley gave the last of his water to a dying Marine and therefore went for 24 hours in the battle without water. He is thus depicted in the famous Felix de Weldon sculpture holding an empty canteen. Later that day, Bradley rushed to the aid of a wounded Marine and, under intense fire, shielded the man with his body and bandaged his wounds. He then pulled his patient 30 yards through heavy enemy fire to a position of safety. Bradley served until wounded in both legs by an enemy mortar shell on 12 March, but refused evacuation until he first ren-

dered aid to two other wounded Marines.

Branch Medical Clinic Albany officer in charge LCDR Gina Trotter said that Bradley’s actions and those of many other American heroes at Iwo Jima reflect an enduring truth, “Even small acts of selflessness are unforgettable.” She encouraged the people she works with to remember that as they deliver care in the clinic or on the battlefield.

Albany’s Branch Medical and Dental Clinic now has a beautiful new facility dedicated to a legendary pharmacist’s mate. They also have a vital mission to fulfill. Noting that the staff had for some time been working out of trailers disbursed in varied locations across the base, MCLB Albany commanding officer COL Joseph Wingard said the new facility is “a 3,000 percent improvement over what was there before.” The clinic

serves some 600 active duty Marines and more than 3,000 dependents, as well as a retired population in excess of 3,500. “This new clinic can be seen as a commitment that this base is a valuable asset and that it will help us to maintain our readiness.”

He noted that Marines from MCLB Albany deployed to Iraq and that the medical facility and the people helped get them ready. As a result, he felt very confident that they were medically deployable and ready to do whatever they had to do. He also said that having a facility like this at your home base when you deploy helps make you feel comfortable that your family will be taken care of.

Branch Medical Clinic Albany, GA, is one of seven Naval Hospital Jacksonville, FL, Branch Medical Clinics located throughout Georgia and Florida. □

Mr. Barnes is Public Affairs Specialist at Naval Hospital Jacksonville, FL.



**Representatives from the Albany, GA, Chamber of Commerce; CAPT Jim Ware, Commander Navy Dental Region South East; BMC Albany Officer in Charge LCDR Gina Trotter; Mrs. Bradley, RADM R.D. Hufstader, Jr.; Albany Mayor Tommy Coleman and Chamber of Commerce President Tim Martin and CAPT John Sentell, Naval Hospital Jacksonville commanding officer cut a ribbon officially opening the new Medical and Dental Clinic.**

# USS *Tranquillity*

## Force Health Protection Starts Here

LT Phillip D. Davis, MSC, USNR  
LT Sean Swiatkowski, MC, USNR

**H**ow does the Navy's busiest clinic provide primary and preventive medical care for over 55,000 future Sailors per year and nearly 6,000 support personnel? The answer is through teamwork with Honor, Courage and Commitment at USS *Tranquillity* Branch Medical Clinic, Recruit Training Command, Great Lakes, IL.

In keeping with the proud tradition of naming Recruit Training Center (RTC) buildings after ships, USS *Tranquillity* (AH-14) was commissioned in August 1998 as a modern outpatient healthcare facility specializing in treating and medically processing more than 50,000 recruits per year. The clinic's namesake, USS *Tranquillity* (AH-14), was commissioned in April 1945. Four months later she responded to the sinking of the USS *Indianapolis* (CA-35), which suffered a fatal torpedo hit from a Japanese submarine. USS *Tranquillity* arrived at the Palau Islands to take on 166 of the USS *Indianapolis* survivors who had endured 4 days in the water and constant shark attacks. USS *Tranquillity* was later reclassified as APH-114 at the conclusion of World War II and used to transport injured veterans of the Pacific Islands campaign to the United States, eventually decommissioning in July 1946.

The modern-day USS *Tranquillity* serves an equally unique and vital mission. Today, RTC Great Lakes serves as the Navy's sole recruit training center. Consequently, all future Sailors receive their first exposure to Navy medicine at USS *Tranquillity*. By providing force health protection through high quality recruit and staff healthcare, the clinic maintains the health of recruits and staff, ensuring the fleet has Sailors who are physically and mentally ready for whatever challenges lie ahead. The clinic philosophy places a strong emphasis on guaranteeing that recruits begin their naval careers with a positive attitude towards Navy medicine. In addition to dispensing primary medical care, the clinic provides immunizations, physical examinations for special programs, and management of

preventive medicine programs. The clinic coordinates specialized medical care through Naval Hospital, Great Lakes, ensuring that recruits receive the care and evaluation they require. Specialized medical care is available through the Sports Medicine and Rehabilitation Team (SMART), and the Recruit Evaluation Unit (REU), which conducts mental health evaluations. The clinic plays a pivotal role in medical surveillance and injury prevention and furnishes logistical support for approved research projects.

Clinic staffing consists of medical officers, nurses, physician assistants, and staff corpsmen. In addition to the assigned staff, a mix of reserve and other personnel augments the clinic during summer surge periods. The clinic workload and staffing numbers reflect the cyclical nature of recruit training with a rise in the number of recruits onboard peaking annually between July and August. Figure 1 displays the quarterly student flow for recruits during fiscal year 2001.

Since commissioning the clinic in 1998, the clinic has continued to work with RTC training staff to decrease lost training time and attrition due to injury and illness.

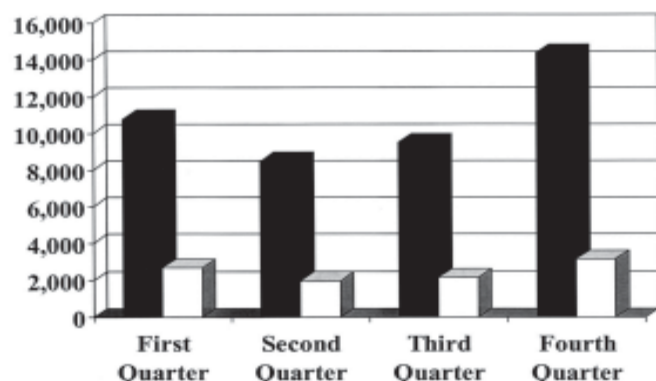


Figure 1: Monthly Recruit Flow FY 01

■ Male  
□ Female



Several conditions have been targeted to decrease medical attrition, although attrition for medical reasons continues to be less than 5 percent. For example, as a result of the asthma clinic, attrition for asthma has decreased from nearly 5 percent to 2 percent overall. By coordinating care with Naval Hospital Great Lakes, one specialist evaluates patients, performs methylcholine challenge test, PFTs, and conducts a thorough history and physical. If the recruit has mild asthma and volunteers for study enrollment, he/she is placed on medications and given a trial of duty. About 50 percent of mild asthmatics will continue through RTC and 50 percent of those will finish and go on to stay in the Navy.

The clinic is a model for teamwork, optimization, and integration in providing efficient medical care. Three primary care teams consisting of corpsmen, nurses, physicians, and physician assistants work in concert to serve the primary medical needs of recruits and staff. Each team consists of a division officer, team medical officer, Nurse Corps officer, physician assistants, independent duty corpsmen, and staff corpsmen. Staff corpsmen attend the sick call screener program and assist in triaging patients. The team names; *Honor*, *Courage* and *Commitment* help reinforce Navy core values for recruits as well as staff members. In addition to the three primary care teams, specialized medical teams enhance the primary care mission and increase medical readiness.

*Team Valor* conducts special physicals for SEALs, rescue swimmers, divers, and nuclear power personnel, submarine as well as aviation duty candidates. A dive medical officer (DMO) and flight surgeon are assigned to conduct special physicals. *Team Valor* offers physical examinations for staff as well as student and recruit personnel. During FY01, the clinic had over 15,940 visits for physical examinations.

The *Sports Medicine and Rehabilitative Therapy* team (SMART) conducts comprehensive musculoskeletal care for recruits. A fully integrated physical therapy team ensures that injured recruits get the physical rehabilitation they need to complete recruit training. The SMART team provides force health protection of recruits through medical surveillance of stress fractures and delivers feedback to training staff regarding injury prevention. As a result of close surveillance of the incidence and types of stress fractures and the resultant training modifications, the overall incidence of severe and other stress fractures has significantly decreased. Recruits, who are injured and unable to continue training are placed in a Recruit Convalescent Unit (RCU) while in rehabilitation. The SMART team, using a multi-disciplinary approach, closely monitors the recruit's progress and meets weekly with RTC training staff to assess the recruit's progress.

As a result, the number of recruits as well as the number of days spent in RCU by the recruit has been significantly decreased. The *Preventive Medicine Team* offers preventive services including the Tuberculosis Control Program and Sexually Transmitted Disease Program. In 2001, over 45,000 PPD skin tests were administered to recruits. In addition, the team conducts public health surveillance for recruits and institutes preventive measures when required.

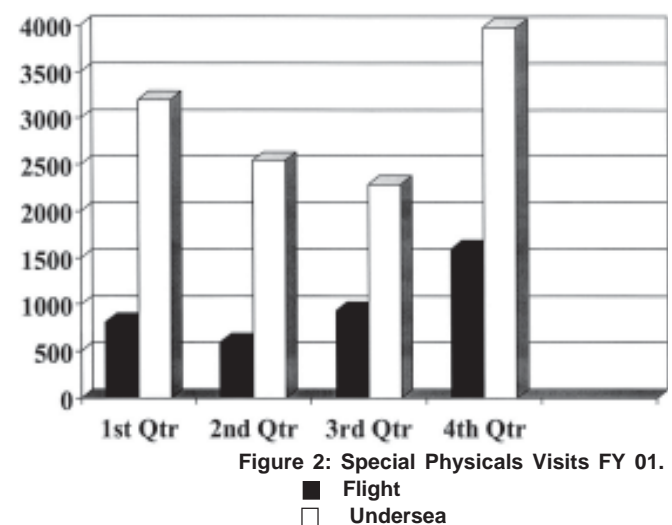
The *Recruit Evaluation Unit* (REU) provides mental healthcare evaluations and counseling. It is staffed by psychiatrists, staff psychologists, and psychiatric technicians and dispenses comprehensive psychological services.

The clinic also serves as the primary care manager for over 5,000 RTC support and staff personnel, maintaining their medical readiness as well as providing primary medical care and coordinating specialty care. The clinic recently began utilizing the Shipboard Automated Medical System (SAMS) to track and maintain readiness of staff personnel.

Ancillary services at the clinic include a digital and conventional radiology suite, pharmacy, and limited services laboratory. Acute-care services are available in a dedicated acute care area including a six-bed treatment bay, trauma, isolation, and immunization rooms. All after-hours and acute care takes place in the treatment bay area.

USS *Tranquillity* serves a unique function in Navy medicine. By focusing on a team approach and integrated services the clinic is able to offer optimal medical care which ensures force health protection of recruits and support staff. □

LT Davis and LT Swiatkowski are assigned to USS *Tranquillity* Branch Medical Clinic, Recruit Training Command, Great Lakes, IL.



# Liberia 2003

## Navy Medicine Assesses the Human Toll of a Nation in Chaos

LCDR Youssef H. Aboul-Enein, MSC, USN



Photos by CDR Eugene F. Smallwood, MSC, USN

Posted along side a road outside Monrovia, this sign became known as "Terry's Cool Sign." The sign emphasizes the bond between Liberia and the United States, and the hope of the Liberian people that "Big Brother" would come to their aid.

Navy medicine saw action in Liberia in 1991 as elements of a Marine Expeditionary Unit evacuated Americans from the capital, Monrovia. Five years later, portions of USS *Guam* (LPH-9) Amphibious Ready Group reinforced the American Embassy and assisted in evacuating Americans and allied civilians from the capital. CDR Eugene Smallwood, MSC, the Senior Medical Planner at U.S. Naval Forces Europe, the naval component under United States European Command (EUCOM), which oversees trouble spots in Sub-Saharan Africa, deployed as part of a Humanitarian Assessment and Survey Team (HAST) in July 2003, when Navy medi-

cine once again went into Liberia. The medical component also consisted of CDR Christopher Clagett, MC. The team was charged with evaluating the extent of the humanitarian crisis in Liberia and to observe how rebels were closing in on President Charles Taylor, Liberia's brutal dictator.

Liberia is a nation built on a weak foundation and originally established by freed African-American slaves in 1822. What evolved was a nation in which the immigrant African-American settlers dominated the indigenous tribes. Such an arrangement would only sow the seeds of resentment in years to come.

**Dr. Clagett performs a dressing change on a Liberian boy injured in a traffic accident. Assisting is Mr. Don Lish, Embassy nurse practitioner.**



The 2003 conflict that brought Navy medicine back to Liberia was a humanitarian crisis resulting from the civil war between President Charles Taylor and rebel insurgent groups named Liberians United for Reconciliation and Democracy (LURD) and the Movement for Democracy in Liberia (MODEL). These insurgent groups, as well as Charles Taylor's own militias, are often untrained 10-17 year olds who abduct, rape, pillage, and murder at will.

In the middle of this chaos are a few non-governmental organizations (NGOs) trying to assist over 3 million Liberian refugees who are sick and starving. However, as a result of the chaos and killing, many have packed and left.

### **The Mission**

CDR Smallwood and the assessment team arrived at Lungi Airport in Freetown, Sierra Leone on 7 July, and caught some rest while waiting for vintage Russian helicopters to ferry them into Monrovia. After checking in with the Ambassador and U.S. Embassy staff, they headed out the next day to an internally displaced person's (IDP) camp named Redemption located in Monrovia.

Liberia is always hot, steamy, and humid. At Camp Redemption, Smallwood and Dr. Clagett met with the clinic staff who quickly told him that cholera and dysentery are the biggest problems. Education, clean water, and sanitation would make a dent in the suffering here. This lament

would be heard again and again as Smallwood and Clagett spoke to the Liberian Health Minister and to local Liberian physicians. The top items on the list were medications and rehydration salts, plus a means to purify water. As the HAST team headed for the next camp, armed insurgents turned away the team, at which point they decided to head back into Monrovia and assess the Samuel K. Doe (SKD) Stadium. The stadium is the home of 44,000 displaced persons, the largest refugee population with 10 latrines for the entire camp; the accepted humanitarian standard is 1 latrine for 20 persons. By the end of the day they had visited three camps and discussed the medical situation with NGOs, U.S. Embassy staff, and members of the United Nations.

### **Initial Impressions**

Monrovia has about 350,000 displaced persons. As the chief medical officer of Phebe Hospital (4 hours from Monrovia) explained, "My hospital has been overrun by insurgents who have looted everything. We have since moved into a tent clinic outside Monrovia, with the bulk of our patients being referred to us by Doctors Without Borders." The Liberian physician said that the country had been without medications and medical supplies for months. "When insurgents see a convoy bringing us supplies they are quick to loot the hospital. No generators, no vaccines, and most of the qualified medical staff have fled the country with their families."





UNICEF sign posted at Ricks IDP Camp.

### Survey of Liberian Hospitals

Smallwood and Clagett visited many hospitals in Liberia in the summer of 2003, and found devastation at every one.

**Government Hospital in Buchanan.** Buchanan is a seaport located south of Monrovia. The insurgents effectively controlled Buchanan. The hospital has a generator but no fuel and of 30 beds only 10 had mattresses. The hospital had no water or electricity and not a single physician. There was a staff of 45 “nurses” of which only six could be considered trained nurses and were in charge. It could not be considered a functioning hospital.

**Oriental Timber Company Hospital.** This is a 50-bed facility taken over by the International Committee of the Red Cross (ICRC). They had ancillary services but no staff. If a payment of \$100 per month could be made it would attract medical staff to this facility. Like the previous hospital it could not be considered functional.

**Cessco Hospital.** This is one of the few functioning hospitals, if it can be called functional with no medications.

**Hospitals in or near Monrovia.** There are three hospitals in the capital, which can barely function (JFK- John F. Kennedy, ELWA-Eternal Love Winning Africa, and

Catholic, a Jesuit Hospital). These hospitals had generators, but could only operate them about 6 hours a day before running out of fuel. Fuel is an expensive commodity in this war-torn country. Cholera is epidemic, because of lack of medications. Hypochlorite is only produced in one location, is continually looted, and whenever chlorine and other supplies are off-loaded they are soon stolen at gunpoint by government militia or insurgents. The medical staff had not or could not be paid; thus many have fled the city. Food was scarce and the feeding of patients became the responsibility of friends and/or family members. Those patients without families typically starved.

Dr. Mohammed Sherriff, a Liberian physician, took CDR Smallwood and Dr. Clagett on a tour of the cholera ward. The ward was a collection of 20 tents and was located outside the hospital. The tents contained tables rather than beds, and each table held two or more patients. Patients lay on the tables with a hole cut out for them to defecate in a bucket. Feces seeped out of children and adults like water, and there were flies everywhere. There were 189 patients in the ward the day that CDR Smallwood and Dr. Clagett visited.

**Phebe Hospital and Clinic.** This hospital and its clinics are located in the remote Bong County, near the Guinea/Liberia border. CDR Smallwood joined a member of the United States Agency for International Development (USAID) and Dr. Sandoe, the medical director of Phebe

Hospital and Clinics. Amid violent exchanges between rebels and government troops the group made their way through Bong County to Barga City, a 4-hour drive north of Monrovia. Dr. Sandoe explained that Phebe Hospital serves a population of 700,000 and has 28 clinics throughout the county of which only 18 are considered functional. There are four physicians who tend to five refugee camps containing over a quarter million refugees. Phebe Hospital has been overrun several times by either insurgents or government troops, who looted everything of value before leaving. The most recent encounter was 2 weeks prior to the HAST team visit. The hospital now stands empty except for a few caretaker personnel. After the attack and looting, the hospital moved closer to the protection of Monrovia. The hospital now operates as a tent clinic 2 hours north of the capital. Dr. Sandoe estimated that of the quarter million IDPs, 17 percent are children and 25 percent are women of childbearing age. The United Nations Children's Fund (UNICEF) does provide immunization programs but the war has caused NGOs to stop food shipments, leaving the refugees scavenging for food in the jungles. Cholera claims the life of one person a day at this camp, and the other major illnesses include malaria and tuberculosis. Diesel generators can run only 4 hours a day and are primarily used for surgery and to run lab equipment. Sanitation standards are non-existent. There is a 30-foot refuse pit behind the clinic with running raw sewage and human waste. Patients lie on the floors, many with open, weeping wounds. There were seven deaths attributed to cholera the day CDR Smallwood visited just at this small clinic.

When there are food shipments it is typically corn-soy dry rations that the patients' families must cook and feed them. Phebe clinic's surgical ward consists of a single treatment table with a large lamp in a non-sterile room. Wards consist of tents; there is a microscope and centrifuge, but no oxygen.

### **Greystone Camp**

Greystone Refugee Camp in Monrovia is right across from the American Embassy and is actually on Embassy property. Over 5,000 displaced persons are in this camp with 70 or more arriving each day. This is the best maintained camp, mostly because of its proximity to the Embassy. There are building materials, a simple barter economy, and a shallow chlorinated well. However, despite the chlorination, the methods by which refugees draw water constantly recontaminates the well and causes diarrhea among refugees.

The chronic medical issues in Liberia are cholera, malaria, malnutrition, including rickets vitamin A deficiency, and protein deficiency. Fecal contamination of shallow wells occurs during heavy rains, as well as cross-contamination of wells by unsanitary containers.

### **Visit with Liberian Minister of Health**

CDR Smallwood recounted his visit with Dr. Peter Coleman, Liberian Minister of Health, who concurred with the HAST team's initial assessment. He provided a lot of qualitative data but sadly no quantitative statistics. The Minister laid out what was needed saying the first item is security for the hospitals, pharmaceuticals, and medical equipment, then access to clean water, and camp sanitation. He ranked in order Liberia's medical priorities with malaria first, then diarrheal diseases, then malnutrition.

### **Navy Medicine Stabilizes Gunshot Victims**

The evening of 17 July mortar rounds and small arms fire were heard not far from the Embassy. The next day saw a firefight between insurgents and Charles Taylor's forces for control of the bridges leading into the capital. The following morning, everyone on the HAST team was pulled back into the Embassy compound and provided weapons training. On the 18th, a French journalist was brought to the U.S. Embassy suffering from a gunshot wound to the abdomen. Dr. Clagett, CDR Smallwood, and Don Lish (a U.S. Embassy nurse) took him into the Embassy health unit and began stabilizing him with oxygen and intravenous fluid therapy and pressure dressings. Once the patient was stabilized, Dr. Clagett and CDR Smallwood took him, with an armed escort, to the JFK Hospital, where they turned him over to Dr. Sherriff for surgical intervention. While transporting the patient, militia and rebels taunted the Marines to come down certain alleyways, an invitation surely to lead to a firefight, robbery, and possible death. AK-47s were everywhere, and the ever-present rocket propelled grenades (RPGs) made for an uneasy environment for the Marines. They stopped several times at roadblocks where drunk and drugged militia demanded extortion money. CDR Smallwood was handed a squad assault weapon and told to keep an eye on the crowd outside his vehicle window.

He recounts that the Marines knew that no matter how bad it got, the medical guys would be there to take care of them. With a degree of respect, they remarked to their company commander upon returning to the Embassy that these medical guys were crazy because they kept cracking jokes in the middle of the ride back through the militia





**Dr. Clagett examines a bombed out bridge leading to Bong County and the Phebe Clinic. This road and bridge provided the major artery from Monrovia to Bong County and points farther north.**

held portion of town. CDR Smallwood would later say it was only an attempt to make the young Marines less nervous, especially after the truck mounted with heavy machine guns pulled out and followed them. Before they got back to the Embassy, they were stopped at four separate roadblocks where the demand for extortion money was repeated. The 10-minute drive back to the Embassy took almost an hour.

On another occasion, Dr. Clagett and CDR Smallwood had to stabilize a local Liberian, who was a guard at the U.S. Embassy, that had a gunshot wound to the upper right chest. This time, JFK hospital personnel picked up the patient as the Ambassador had decided no one was allowed outside the Embassy walls. On another occasion, CDR Smallwood was standing at the kitchen window glancing up toward the UN headquarters. Moments after he turned to walk away, a small arms round shattered the kitchen window where he had been standing.

Dr. Clagett also treated a Liberian boy who was a victim of a vehicular incident involving an Embassy vehicle. Suffering from minor abrasions, the boy was taken back to the Embassy for treatment and seen daily for dressing changes. A smile returned to his face several days later when the Ambassador presented him with a brand new soccer ball.

By 21 July mortar rounds had either hit inside the Embassy compound or were too close for comfort. The first wave of American citizens were evacuated out of Monrovia along with journalists, media, and NGOs to

Freetown, Sierra Leone by HH-60 helicopters, the U.S. Air Force version of the Blackhawk. Over the next 3 days, four members of the HAST team also left. CDR Smallwood would be one of the last to leave on 24 July.

### **A Liberian Odyssey**

Dr. Clagett and CDR Smallwood's observations and interviews, along with those from the rest of the HAST team, would be presented to GEN James L. Jones, USMC, Commander, U.S. European Command, as part of a document entitled, "United States European Command Final Report on Liberia." It would reveal the extent of the humanitarian and medical crisis in the nation and cover health, water, sanitation, and shelter. The report would offer information on runways, ports, and infrastructure capabilities for handling medical evacuation of patients. It also included an assessment of what NGOs and the UN were doing and where their personnel were operating.

Members of Navy medicine who have served in a HAST team are typically the on-scene first responders to a major crisis and what they report determines what medical capabilities will be needed. What then transpires is the decision of the National Command Authority. □

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LCDR Aboul-Enein is currently specially assigned as Middle East Country Director at the Office of the Secretary of Defense.

# Defining Heroism

James O. Finnegan, M.D.

**Y**ou've seen it dozens of times—an unexploded shell or bomb is located in a precarious position and unless removed or defused, the entire city or world will be blown to smithereens. Invariably, one heroic individual steps up and attempts the nerve-racking, gut-wrenching task of defusing the explosive at great personal risk. On TV and in the movies, given a fair amount of sweat and shakes, the hero is invariably successful, usually seconds before Armageddon. It's good stuff. It keeps you on the edge of the chair with an increased pulse and sweaty palms. We all imagine that we would function in those situations just as the hero did. But, would we?

I know someone who did—Ed Feldman, Dr. Ed Feldman, LT Ed Feldman, my friend Eddie—the greatest war hero I have personally ever known. You may well ask, “Who in the hell is Eddie Feldman? If he's so much a hero, why didn't they retire his uniform and hang it alongside SGT York's and Audie Murphy's?” Well, I'll tell you what, if he did what he did during World War II, a conflict that enjoyed the backing of every red and blue-blooded American, he'd probably have a statue in Washington, DC, or at least a large plaque in Los Angeles.

As it was, his heroism occurred in Vietnam while the anti-war movement was nearing its peak in the United States and all but drowning out or flatly rejecting any possibility of good news from Southeast Asia. The Marines

noticed. I noticed. But the rest of the world did not notice and could have cared less.

What did LT Feldman do? In military terms he received the Silver Star for gallantry. The citation accompanying that medal mentions such things as “uncommon valor,” and “total disregard for personal danger.” But no citation can adequately describe the scene that unfolded that day in Vietnam.

Dr. Feldman was out in the field with a company of Marines who were taking heavy incoming fire. One of the casualties scared the living bejeezus out of everyone when they realized that an unexploded shell was embedded in his abdominal wall near his liver. No one wanted to touch the guy, let alone move him. Eddie calmly came on the scene, ordered everyone out of the way, reassured the frightened Marine who was amazingly awake, and then slowly removed the shell from his abdomen. The shell was then taken from the area and detonated. The Marine lived, Ed Feldman was decorated with a Silver Star, and became a true grunt hero known but to a few.

It would be easy to write this off as one more amazing but true little war story, but think about it for a moment. Same scene except you're in LT Feldman's position. Go on, conjure up the picture in your mind. Contemplate how much they'll find of you if that mortar round explodes. Ignore the possibility of moving him, evacuating him, or passing the risk on to oth-

ers. Step up, take hold of the shell in your bare hands, bare face, bare everything. Lift it out of the grunt's belly. Have it safely removed from the area. Dress the wound and go about your business. Could you? Would you? The Silver Star? Gimme a break! How about a million bucks and the Medal of Honor?

There's more. There actually was no such thing as “business as usual” for LT Feldman. He could have and should have stayed at the Delta Med section of the Dong Ha combat base and helped to care for casualties in a safely bunkered triage area. But not Eddie. Every time a Marine platoon or company got involved in a firefight and took casualties and screamed for a doctor, Eddie would grab his M16, jump on a helicopter, and fly out into the midst of the action to administer to Marine casualties.

You should know there are trauma experts who think physicians can do little under such circumstances and that the most expeditious way of caring for such combat casualties is to load them quickly onto helicopters and get them back to a combat base where surgical teams can care for them. Tell it to the Marines.

If you're not already a rabid fan of Eddie's, let me share another aspect of his personality and performance. During January, February, and March of 1968, on a small, red clay plateau in the northwest corner of South Vietnam called Khe Sanh, units of the 3rd Marine Division were besieged by a large North Vietnamese division estimated at 30-40 thousand men. Eddie was with me as part of my surgical team during that siege. At times, the Khe Sanh base would take up to 3,000 rounds of incoming artillery and mortar fire per day. Casualties from the base and the surrounding hills came to our Charlie Med bunker at rates of a few at a time to dozens at a time, mostly brought in by heavily armed



choppers. We treated them emergently, then med-evaced them out by helicopter, frequently under heavy enemy fire. During that time, Eddie showed another aspect of his bravery. He never flinched, never showed a Marine casualty anything but smiling confidence. He cared for the wounded day and night, helped move litters on and off choppers un-

der heavy fire, while displaying a calm and competence that reassured the wounded, our corpsmen, and me.

Somehow a Silver Star seems inadequate. I don't know much about decorations. It seems that most of them are for singular acts of heroism. But how do you reward dozens or even hundreds of heroic acts—deeds most men wouldn't contemplate, let

alone carry out? The answer, of course, is that there is no adequate reward or recognition.

I have been privileged to have Eddie as a dear and much loved friend for over 30 years. I can only hope that others who read this will come to admire him as I do. □

Dr. Finnegan is a former surgeon with the 3rd Medical Battalion, 3rd Marine Division. He resides and practices medicine in Pennsylvania.

\* \* \*

In 1973, some 591 American POWs were released from captivity in Southeast Asia and flown back to U.S. territory in what was labeled "Operation Homecoming." Overshadowing the resulting fanfare were many unanswered questions. What about the rest of our MIAs and "Last Known Alive?" Are we going to forget the many valiant warriors who fought for their country in Vietnam, Laos, and Cambodia? The answer was a resounding NO!

## Mission to Vietnam Finding Those Who Will Never Be Forgotten

By the end of the Vietnam War there were 2,585 Americans unaccounted for in Southeast Asia. Organizations like the National League of POW/MIA Families became the

nation's corporate memory as they fought hard for the fullest possible accounting of the missing. To date, their famous "You are not forgotten" POW/MIA flag is the only other flag, besides the "Stars and Stripes," to fly over the White House. This black flag of remorse flew high and painfully in our country's consciousness as well.

Partly due to a massive outcry, and the many questions that lingered, Congress established an organization to investigate, account for, and locate not only the remains of Americans lost in Southeast Asia but also those missing in conflicts from World War II to Vietnam.

The Department of Defense Joint POW/MIA Accounting Command (JPAC), set up in 1992, has presently recovered some 500 sets of remains of missing Americans and identified 323 of them.

However, the task remains herculean. Success is contingent upon tenuous international agreements be-



Repatriation ceremony, Da Nang, Vietnam.

Photo by author

tween United States and the Socialist Republic of Vietnam (SRV), Laos, and Cambodia, even though agreements between the U.S. and these Indochina governments now allow Vietnamese witnesses to assist JPAC in its missions.

Recently, JPAC sponsored its 73rd Joint Field Activity mission to Vietnam. Comprised of a highly skilled staff of JPAC regulars (i.e., civilian and military investigators, analysts, linguists, and oral historians) the activity was joined by a number of medical “augmentees,” mission specific specialists, which included an Air Force Medical Corps officer, three Air Force independent duty medical technicians (IDMTs), two Navy independent duty corpsmen (IDCs), and one Navy physician assistant, CDR Steven Galeski, MSC.

CDR Galeski recalls receiving the telephone call from BUMED POMI [Plans, Operations, Medical Intelligence] shop, “I was told the mission needed a physician assistant. The JPAC doesn’t have its own medics so they recruit medical augmentees for each mission. I wasn’t about to task one of my PAs without knowing firsthand what it was all about. I’ve always believed that one should lead from the front, so I volunteered myself.”

In the ensuing days the full scope of mission was revealed to those medical specialists by way of a Warning Order (WARNOD).

AN INDEPENDENT RESEARCH TEAM (IRT) WILL CONDUCT A JOINT FIELD ACTIVITY (JFA) WITH ONE RESEARCH INVESTIGATION TEAM (RIT), AND SIX RECOVERY ELEMENTS (RE). THE MISSION WILL BE CONDUCTED IN FIVE PHASES:

PHASE I (PREPARATION):  
ISSUANCE OF WARNING

ORDERS....AUGMENTEES REPORT TO JPAC.

PHASE II (DEPLOYMENT TO VIETNAM): IRT TRAVELS TO VIETNAM VIA ONE CHARTERED HAWAII AIRLINE PLANE; ALL MISSION SUPPLIES FLY ABOARD AN AIR FORCE C-17. UPON ARRIVAL IN DANANG, VIETNAM ELEMENTS MOVE TO MISSION SITES AND PREPARE INVESTIGATION AND RECOVERY OPERATIONS.

PHASE III (FIELD OPERATIONS IN VIETNAM):

(1) INVESTIGATIVE ELEMENT (IE) WILL INVESTIGATE APPROXIMATELY 23 CASES IN FOUR CENTRAL AND SOUTHERN VIETNAM PROVINCES.

(2) RIT WILL RESEARCH APPROXIMATELY SEVEN CASES IN VIETNAM.

(3) RE’S WILL RECOVER SIX CASES IN CENTRAL AND SOUTHERN VIETNAM

PHASE IV (REDEPLOYMENT FROM VIETNAM TO HICKAM): TEAM REDEPLOYS FROM DANANG TO HICKAM AFB...

PHASE V (POST DEPLOYMENT): AUGMENTEES RETURN TO HOME COUNTRY.

This would not be a mission to Oz by any means. Medical specialists were required to learn the geo-political makeup of the SRV and the potentially fatal diseases and other dangers they would encounter. “Dengue fever, Japanese encephalitis and, of course, malaria were risks,” explained Galeski, “and each required immunization. There is a form of malaria native to the area so potent that people have been known to die within 24 hours of being bitten by the infected mosquito.”

He further illuminates this world. “Transportation in Vietnam is depen-

dent upon nationals. Americans are not allowed to operate a motor vehicle in Vietnam. The rules are very succinct. Americans cannot ride in a vehicle in the countryside at night either.”

Following a week of orientation in Hawaii, undertaken by the JPAC, where the topics of malaria, preventive medicine, emergency dental, and MEDEVAC procedures were addressed, augmentees took a long flight to their staging ground. The Joint Field Activity gathered in Da Nang, and specialists and their equipment split into the respective Research Investigative Team (RITs), Investigative Element (IEs), and one of five Recovery Elements (REs) before embarking into the beating “heart of darkness.”

Certainly, no one was going to confuse Vietnam with Greenland. First impressions of Vietnam were very consistent among mission augmentees. HMC Stephen Rogers, an IDC attached to the investigative element which traveled throughout Vietnam to determine if locales were viable places to search for remains, recalls arriving in an “unbelievably hot environment.” Chief Rogers added “When we were in Hawaii we began to get acclimatized, but nothing can prepare you for the heat in Nam. You are working in conditions of 100 degrees all day long with 100 percent humidity.” CDR Galeski noted, “It is what you see in movies like ‘Apocalypse Now.’ Besides mosquitoes, the biggest medical threat we were up against were heat-related conditions—heat stroke, and fatigue.” As for the intriguing notion of “Apocalypse Now” CDR Galeski points out, “There is actually a dance club in Saigon (Ho Chi Minh City) named after the film, fully equipped with a large mural of Marlon Brando painted on the wall of the club. At the beginning of the mission I definitely felt



some of the same uncertainty Martin Sheen's character felt entering the unknown. How successful was this mission going to be? What were we going to find, besides COL Kurtz that is?"\*

Medical specialists CDR Galeski, Chief Rogers, and their respective teams traveled through the provinces under these uncompromising conditions in 4-wheel-drive vehicles, former Soviet helicopters, and on foot. The infamous names one reads about in Vietnam War books—the Mekong Delta, the Ho Chi Minh trail, major cities like Saigon and Da Nang—were embedded with clues for this Sherlock Holmesian operation. CDR Galeski, assigned to the RIT, journeyed into the many cities and villages where witnesses of crashes were interviewed. As CDR Galeski explains, "The RIT included a JPAC linguist, one debriefer, and three Vietnamese officials. These officials are in charge of tracking and setting up these interviews. Now, after a witness was interviewed, our team sent the information back to the JPAC for processing whereby the next mission's IE investigates the feasibility of the report. If that team correlates the site with an MIA, an RE excavates the site in a following mission."

Sometimes these interviews proved trickier than expected. CDR Galeski relates, "On a hot day in the mountains our team visited the People's Army of Vietnam (PAVN) cemetery with two elderly witnesses where an American serviceman was supposed to be buried. According to one witness the remains would have been exhumed and buried at a 'Vietnamese hero's cemetery' elsewhere. Another witness said he was not exhumed and is still buried there. Things were not always clear-cut and memories change with time. In fact, one of

the biggest problems the JPAC is facing is that witnesses so crucial to the missions are not getting any younger." Indeed, the exact locations of the servicemen were at times open to interpretation, hence the need for the RIT and IE.

Attached to the IE, Chief Rogers visited four provinces and assisted in the investigation of some 23 cases. He paints a very striking picture of one particular investigation. "We went up to a site looking for the remains of an aircraft crash. To correlate this site we had to look for blue glass. Most of the crash sites have been scavenged of the metal and glass evidence by poor Vietnamese farmers and villagers so you don't usually have much to go with. This particular site had been turned into a cultivated field. We were looking throughout the crater and couldn't find anything. After a few hours of sifting through the crops and on the verge of leaving, a farmer comes up to us with a handful of metal. Our team captain asked him where he found it and the man pointed to a spot some 150 yards away. We went down there and started finding metal fragments and blue glass. We were surrounded by village kids. After they saw what we were doing they were down on the ground with us picking this stuff up and handing it to us. Later when I was talking with our team captain a little girl reached over, tugged on my shirt sleeve, and gave me a handful of metal. When we looked through this small pile we found a dog tag with the name of a man we were looking for."

Culminating some 30 days after the beginning of the mission, the teams gathered in Da Nang in the somber yet important task of repatriating the remains of five American servicemen uncovered from the previous mission's RE.\*\* For CDR Galeski and HMC

Rogers this event proved most rewarding. As Chief Rogers explains, "I felt a sense of both pride and humility. Bringing home these Americans to their families gives you a sense of tremendous accomplishment."

In the 23 cases that were investigated only three of them were recovered and will be repatriated by the next mission. Sad to say, not all missions are as successful as the JPAC hopes. However, CDR Galeski does see a golden horizon in the JPAC's future. "The legacy of JPAC will be one of having successfully fulfilled its mission and having brought closure to long grieving families. Hopefully, even more of the honored war dead will be brought home. Then, JPAC will truly live up to, and exceed, the motto: 'You are not forgotten.'"

\*In Francis Ford Coppola's movie "Apocalypse Now" (1979) Captain Willard (Martin Sheen) is tasked with finding a renegade military outpost led by the mysterious COL Kurtz (Marlon Brando).

\*\* Between missions these remains were housed at the Joint Forensic Board in Hanoi made up of American and Vietnamese forensic experts who review the remains of objective evidence to determine a high probability that they are truly Americans. □

—Story by André B. Sobocinski, Assistant Historian, and staff writer for *Navy Medicine*, Bureau of Medicine and Surgery (M00H), Washington, DC.

# Executive Medicine Career Plans

HM2 A.R. Nizar-Moses, RN, USNR (TAR)

Looking for a position in executive medicine with leadership? Look no further than your personal computer; executive skills training is now virtually everywhere. The Virtual Military Health Institute (VHMI), now the Joint Medical Executive Skills Institute (JMESI), and the Joint Medical Executive Skills Program (JMESP) can assist you in achieving your professional goals.

In 1992, Congress mandated that commanders of military treatment facilities must possess certain administrative competencies before assuming their command positions. In 1996 and in 1998, that guidance was expanded to include prospective Deputy Commanders, Lead Agents, and Managed Care coordinators. The JMESI and the Naval Medical Education Training Command's JMESP are now in place to help candidates meet those requirements.

The primary effort focuses on a group of 40 executive competencies originally developed in the early '90s. The competencies represent the minimum unique skill set healthcare executives must possess, and make up the Department of Defense's professional executive skills list. In the past decade, the competencies have undergone a few minor revisions, but they remain a key element in meeting the congressional mandate. To see where you personally stand compared to the 40 competencies, access <https://nshs.med.navy.mil/eme2/home.asp>. Read the opening page on the web site for an overview and check your status electronically. The Core Curriculum link on the right of the web page describes the 40 competencies and their associated behaviors. If you have problems, there are links on the page to helping you contact the JMESP for assistance.

Together, the JMESI and JMESP are strategically changing the way our leaders are educated. From distance learning (DL) modules to an online self-assessment tool, they are redefining traditional military leadership training through innovative and blended educational methods. In addition to overseeing the 40 competencies, JMESI publishes a catalog of executive medical courses offered by each service and the DOD. The catalog describes available courses (including descriptions and points of contact) taught within the Military Healthcare System and identifies which of the 40 competencies each course covers. JMESI is developing a Web-Based Self-Assessment Instrument. Once complete, the instrument will give officers (Active Duty) remote access to evaluate their own executive skill sets vis-à-vis the program's 40 executive skills competencies. The JMESP is available to assist you at any time and can be contacted using the web site above or through the Center for Force Health Protection site via Navy Knowledge On-line JMESI's web site is [www.jmesi.org](http://www.jmesi.org) and can be found on the JMESP web site as a hot link. JMESI hosts a complete executive skills reference library that includes the distance learning courses, the executive self assessment tool, the MHS executive course catalog and links to other helpful executive resources.

JMESI and the JMESP are striving to serve military healthcare leaders throughout the globe. If you have questions, HM2 Nizar-Moses can be reached at: [anizar-moses@nmetc.med.navy.mil](mailto:anizar-moses@nmetc.med.navy.mil) and CDR Ehresmann can be reached at: [eehresmann@nmetc.med.navy.mil](mailto:eehresmann@nmetc.med.navy.mil) □

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# Medicine for Marines

## Navy Medicine with the United States Marine Corps at Okinawa and Inchon

### Part I - Okinawa

ENS George L. Cowan, MC, USN

When a Marine shouts “Corpsman!” he calls upon a U.S. Navy medic to come to his side and provide immediate and often lifesaving care for himself or his buddy.

Throughout U.S. Marine Corps history whenever Marines have gone into battle, their Navy corpsmen brothers have been at their side. So it was throughout World War II and the Korean War. But Navy medicine support for the Marines in these two, distinct wars, had its own flavor. Separated by a mere 5 years, lessons learned in the former were either discarded, or more likely forgotten, in the latter.

The island-hopping of World War II, uniquely Marine, was not to be the major warfare maneuver in Korea, except for the amphibious landing at Inchon. Comparing the medical support of the amphibious landings at Okinawa with the landings at Inchon allows a comparison of how U.S. Navy doctors, dentists, and corpsmen saved lives in both these Marine campaigns. Major differences aside, a thoughtful look at these operations may provide insight to future medical planners and those that serve to save Marines.

The Joint Chiefs of Staff prepared the strategic plan to make an amphibious assault on Okinawa by 2 October

1944. Following operations by GEN Douglas MacArthur to invade Luzon in late December 1944, a Marine amphibious landing was to take place in January of 1945. The amphibious assault on Okinawa would then take place on or about 1 March 1945.(1) The operation was code-named ICEBERG.

The Navy medical staffs in 1945 had the advantage of experience from earlier landings and campaigns as the Marines island-hopped across the Pacific. They also had the option of time to allow for planning and training. Planners then drew up the details to provide for the care and evacuation of sick and wounded personnel, sanitation efforts, and medical logistics.(2)

Staffers required sufficient time to plan for the landings at Okinawa. Pushed back to 1 April 1945 after the successful but costly Marine landings at Iwo Jima, the medical staffs faced a daunting challenge. “The magnitude of the medical problem becomes apparent when it is [sic] realized that in the Okinawa operation expeditionary troops numbered nearly 500,000 men, while naval personnel aboard more than 1,600 ships exceeded 350,000.”(3)

There would be field hospitals for both the 1st and 6th Marine Divisions (MARDIV) with the addition of two



Photos from BUMED Archives

**Hospital corpsmen attend victims of a kamikaze attack on USS *Bunker Hill* (CV-17).**

evacuation hospitals attached to the III Amphibious Corps to aid in both the evacuation of casualties and to provide the opportunity for specialized care as needed.<sup>(4)</sup>

The specially adapted tank landing ships LST(H), introduced at Iwo Jima, would again be used to handle casualties. LCDR George J. Miller, MC, conceived the idea of the LST(H) in 1944. Naval medical officers initially vetoed plans for converting LSTs to handle casualties.<sup>(5)</sup> Cooler heads prevailed and the LST(H) was approved and demonstrated its worth at Iwo Jima. Regarding their use at Iwo Jima, "This use of LSTs saved many, many, lives of wounded men who received treatment on the LSTs. If they had not received this treatment and had to be taken from the beach all the way to the hospital ships, many would have died before they reached the ships."<sup>(6)</sup>

Eight LST(H)s were planned for Operation ICEBERG. Four were to support the Marines in the Northern Attack Force, while the remaining four were to support the Southern Attack Force of the XXIV Army Corps. Additional landing craft (LCVP) were planned to provide direct evacuation to hospital ships in support of the attacks on the islands of Kerama Retto to the west of Okinawa.<sup>(7)</sup>

The Okinawa plan also included six hospital ships (AHs), two APHs (transports fitted for evacuation of wounded), and two converted attack transports (APAs). Anticipated critical cases required two of them to be held in the objective area throughout the operation. Further evacuation

to the United States through the Marianas Islands and Hawaii would be accomplished, as circumstances would permit.<sup>(8)</sup>

In the 1st Marine Division, 40 hospital corpsmen were assigned to each infantry battalion. This provided each platoon with two hospital corpsmen. Among rifle companies, litter bearers trained in first aid were designated in each combat team to provide casualty evacuation to the aid stations.<sup>(9)</sup>

Problems with the coordination between various supply facilities did not deter other medical factors being planned as Operation ICEBERG took shape.

Fresh, whole blood was ordered directly from the United States, as had been done at Iwo Jima.<sup>(10)</sup> Sanitary squads prepared DDT in oil spray to be used on all dead bodies and livestock to prevent epidemics of mosquito and fly-borne illness. Only about 7,000 jungle-kits, deemed superior to the standard first aid kits, could be obtained in time for Okinawa, although medical planners disapproved the requisitions for medicinal brandy, thought to be of good use in treating fatigue, shock, and exposure.<sup>(11)</sup> The threat of enemy action against the forces in transit to Okinawa was very real. Maximum dispersal of personnel, supplies, and equipment was required. "In the case of the III Corps Medical Battalion, Corps Evacuation Hospital Number 2, and Corps Evacuation Hospital Number 3, each was embarked in three sections on different ships as a precaution



**Wounded Marines on Okinawa await a medevac flight in a concrete revetment formerly used by the Japanese to protect their planes.**

against loss by enemy air or surface action.”(12) This dispersal for the III Corps and the two evacuation hospitals had poor results in terms of their landings.

Japanese opposition to the landings at Okinawa was rather light when compared to earlier amphibious assaults. This allowed for the medical components to arrive quickly and set up their facilities as the forces pushed inward. The 6th Medical Battalion with the 6th MARDIV began landing just 2 hours after the initial assault and was established to handle emergency casualties within an hour. The 1st Medical Battalion followed the 6th ashore on L+1. Personnel quickly set up the respective hospitals and the evacuation chain was maintained as Marines quickly penetrated toward the center of the island.(13)

Because of the dispersed personnel and supplies of the III Corps Medical Battalion and the two evacuation hospitals,

*. . . there were insufficient men to guard medical property effectively when it was discharged on many beaches, in many boats, and from many ships . . . Notwithstanding urgent pleas by the units involved and by the corps surgeon, the gear was dispersed over numerous landing beaches and the anticipated loss of gear resulted . . . The resulting confusion necessitated the expenditure of much effort on the part of medical personnel*

*to locate and collect their equipment and supplies. It also entailed the loss of valuable time in setting up hospital facilities, nullified the purpose of combat loading, and retarded the employment of medical personnel for the care and evacuation of wounded, for which they were needed. . . .(14)*

Surgical care was provided as close to the front lines as possible during the Okinawa campaign and a total of 1,273 operations were performed in the combat environment with Navy dentists often providing anesthesia support. To allow for increased flexibility, a mobile operating room was improvised from an amphibious tractor. While equipped to take surgery to the troops, it was also protected with its own armor and could withstand machine gun fire. Additionally, a discarded radar trailer was converted by Navy Seabees into a mobile surgical unit and was landed on the second day of the assault. It was used throughout the operation on Okinawa.(15)

Light casualties, allowed for the development and refinement of the evacuation chain over primitive roads and in torrential rains, as the operation proceeded and fighting intensified.

The bad roads and poor conditions combined with distances of up to 30 miles taxed the evacuation efforts of the medical personnel. In the northern area, the 6th





**A wounded Marine receives blood plasma during the battle for Naha, Okinawa.**

MARDIV employed LST(H)s and amphibious trucks (DUKWs) in evacuating casualties by water to avoid the bumpy, overland trips.

As conditions worsened and travel of even a few miles became exceedingly difficult, the 1st and 6th MARDIVs began to use small, observation aircraft to move casualties by air. Using sections of concrete road near their collecting stations as runways, the Marines would send patients by air to landing strips near the corps or division hospitals. This novel evacuation method alone accounted for over 700 casualty evacuations from the 1st MARDIV during 11-30 June 1945.<sup>(16)</sup>

Both the Navy and Army handled evacuation of casualties by air out of the operational theater to Guam, while

the rotation of hospital ships also provided a sea-borne route away from the hostilities.

The total number of casualties at Okinawa through 27 May 1945 was 38,420, over 20,800 of which were U.S. Marines; 560 Navy medical personnel accompanying the Marines were also casualties at Okinawa.<sup>(18)</sup>

The killed-to-wounded ratio at Okinawa was 1 to 5 for the U.S. Marine Corps and 1 to 4.25 for the Army. Interestingly, because of the Japanese kamikaze operations against the U.S. Fleet, the killed-to-wounded ration for the Navy was 1 to 1.<sup>(19)</sup>

Of all the factors that weighed heavily upon the Medical Department in Okinawa, the problem resulting from the kamikaze attacks was the most significant. Kamikaze

attacks significantly altered carefully organized plans for shipboard casualty management. Doctors and corpsmen alike could often only provide the most basic first aid to their injured comrades as they fought to save their ships.

The increased percentage of extensive burns due to these suicide attacks taxed the operation's blood plasma supplies. As a result, a floating plasma bank was established aboard *Crescent City* (APA-21) in addition to the plasma bank ashore, and medical planners advised the screening vessels—the ships most threatened by the kamikazes—to increase their plasma complement from 5 to 20 percent.(20)

Among the varied lessons learned during Operation ICEBERG, several stand out. Throughout the medical components, use of veteran doctors and corpsmen ensured available experienced personnel to provide direction as needed. Replacement medical personnel, although provided, lacked sufficient training to be totally effective.

Circumstances established a complete and cohesive chain of medical care. This chain started with the corpsman giving aid on the scene, often under enemy fire, and the designated litter bearers delivering the injured Marine to the closest aid station.

Each casualty received immediate medical care and then jeep, ambulance, or airplane evacuated the patient to a hospital outside the area.(21)

The use of fresh, whole blood shipped directly from the United States saved numerous lives. Over 36,684 pints of whole blood arrived in the operational area.(22)

Finally, the extensive planning and preparations performed by the medical staffs contributed to the overall success of Operation ICEBERG.

As World War II ended with “V-J Day” in August of 1945, little did the United States know that within 5 years, another conflict would throw U.S. Marines along with their Navy corpsmen and doctors against a beachhead. Americans, tired of war, thought nothing of the massive de-mobilization of troops and equipment as the nation shifted into a well-earned peace. (To be continued.)

Summary of the Okinawa evacuation from 1 April to 27 May 1945:(17)

Casualties evacuated by hospital ship (AH) — 11,731

Casualties evacuated by other surface vessels (APA, APH, BB) — 1,405

Casualties evacuated by air — 11,771

Total — 24,907

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# Project Windstorm

## A Cold War Memoir

### Part VI

CAPT James Helsper, MC, USNR (Ret.)

In addition to the special gear issued to us by the Navy, we had brought along some personal items. Most of us had an ordinary radio or a clock-radio, the latter's clock being of use, but we were out of range of any radio stations. A few had brought some amateur radio gear with them, but this was strictly forbidden because of the secrecy imposed on our mission. We thought ordinary broadcast radios would be useless, since we were so far from civilization, but we had a lot of time on our hands, and at night we would scan the dial. We did find some broadcasts out there, some of which were ominous, and assumed they were contact between tanks fighting in Korea, several thousand miles away: "Watch it, Sarge, there's a tank coming up the hill at 4 o'clock, take him!" We could also hear occasional snatches of commercial broadcasts from Alaska, and even from the U.S.

Then one night on a frequency later disseminated to everyone, we heard a voice without an accent, someone who called herself "Moscow Molly."



The ward.

Photos courtesy of author

"Here's Molly again, guys. Don't tell me you're still working your heart out for that bastard skipper of yours. Slow down, take it easy, and relax!" She obviously knew of us as "enemies of the Soviet people there on Amchitka" as she termed it. She named the commanding officer as well as the executive officer and several others, and told how they would be

hung [sic] in Red Square as enemies of the people of the world for building rocket-launching platforms aimed at the heartland of Russia.

"Just take it easy, guys, you don't want to bust your back for that cocky bastard pushing you to work your ass off. I'm going to play you a love song while you lie there on your bunk and think of home and that warm hug from



your wife, while you freeze your n . . s off up here!”

She’d go on, “Everyone on Amchitka will be punished for helping those guys.”

Her diatribe would continue, “Anyone who helps in the dastardly attacks against the Soviet people will be tried in a People’s Court in Moscow. The Soviet people will cheer as each of you is hung in Red Square, by Lenin’s tomb. It will be done for all to see.”

Dick and I were never called by name. Perhaps she didn’t think doctors were important enough. However, at least 10 of the officers on the island, and their jobs, were correctly named.

In between her monologues she would play records; most were scratchy old records of World War II songs and popular dances. She would play “In the Mood,” “Bei Mir Bist du Schoen,” “Don’t Sit Under the Apple Tree With Anyone Else But Me,” and other easily recognizable tunes, sometimes played three or four times in a row, and then she would come back on the air.

She tried other tacks: “Hey, guys wouldn’t it be great to have a couple of brews and come down with me and snuggle up while we get each other hot, and then we’ll do it together?”

“Come on guys, wouldn’t you rather make love than work your ass off on that f . . . n’ project out there?”

Then there was the one, “Hasn’t that f . . . n’ wind gotten to you yet? Wouldn’t you rather be with me, all warm and cozy in bed?”

“Hey, fella, how about a slug of vodka and a little beddin’ down? I’m your mate, sailor.”

This surely got everyone’s attention, and she knew how to punch all

the right buttons, especially with more than a thousand lonely men stuck on this awful island. What had happened to all those special security clearances? Since the status of the work goal, seemed accurately named, it led to the conclusion that there was a spy among us on the island. Could it have been any of us MCB 3? Perhaps it was one of the crew on “Sea Otter” Jones’ boat? Perhaps someone else was actually on our island hidden in a cave? It appeared that someone was in radio contact with the Russians, revealing what we were doing on the island.

“Moscow Molly” became a regular fixture on the radio at night, and she continued to name names and widen her threats to “enemies of the Soviet people.” She assured us that Russia would soon rule the world.

All of this added a lot of speculation to the discussion in the nightly mess, and “Molly” was the focus of attention during dinner conversation.

Despite these broadcasts, we continued the charade of having our mail substantially delayed. We heard many

more warnings about writing home and telling of our mission on the island. Certainly our feeling of security was threatened.

Moscow Molly’s regular broadcasts were probably the reason for the orders from the skipper, that everyone would have shooting lessons on the rifle range. We were ordered to become competent with the pistol and the .30 caliber carbine that had been issued to us. This brought up concern regarding the “klutzes” who would never learn.

Dick and I tried to argue this, but we were informed that “Everyone would learn to shoot, period.” Most of the Seabees had their arms training at Port Hueneme before we shipped out, and it appeared that Dick, Gus, and I were the only targets of these orders.

Among the many people who made up a Mobile Construction Battalion was a small group of Marines assigned for our protection. There were eight of them, under a sergeant who had set up in an abandoned rifle range near the second runway, creating a guard



Dentist and his crew at work.

station there. They had their own quonset. "Semper Fi" signs, Marine slogans, and recruiting posters adorned their walls. They cooked most of their own meals there and generally kept to themselves.

We left Gus available at the infirmary, and Dick and I arrived at the range for our first lesson. We met the sergeant who was a former DI (Drill Instructor). He was a typical DI, as portrayed by Hollywood movies. He stood erect, with a short crew cut, and a carefully pressed uniform, even on Amchitka. He had spit-polished shoes and barked his statements as if they were commands. He was a bit overweight, and hid his paunch by his erect military posture. His tie was carefully tucked into his shirt below the third button, and his campaign hat was secured in his belt. Although it was cold and windy, he did not wear a jacket.

His voice came almost at a shout, "When you're here, SIR, remember that I'm the boss; when I say jump, you jump. Do you hear, Sir?"

We meekly agreed that he was the boss. That settled, we went inside and he began to teach us how to take down our "weapon;" it wasn't a gun anymore. We certainly would never forget it was a "weapon." In addition to the .30 caliber carbine, we also had to learn to use the .45 pistol usually carried by officers. We started with the pistol—how to take it apart and reassemble it. And we practiced this many times.

"I'm only going to show you this once, SIRS, so don't forget it," he blustered. And then he blindfolded us, and we had to do it that way. It took several hours before Dick and I could do it quickly enough to please him. By then we thought we could do it in our sleep.

"Do it again, faster this time, and do it right," he insisted.

Finally, without ever firing a shot, he sent us home with the sear from the trigger mechanism, along with a piece of emery cloth to carry in our pocket. We were instructed to polish that little device until it shined. This would give our weapon a "hair trigger." Dick and I weren't sure we wanted a "hair trigger," but we thought it was better not to bring that up with the sergeant.

We were seen walking around with our hands in our pants pocket, polishing the device with the emery cloth, a sight that elicited some derogatory comments from some of our comrades: "Hey, Jim, you got an itch in your b . . . s? How'd you get jock itch up here?"

At our next session with the sergeant we had to do the same thing with the carbine. We still hadn't fired a single shot, and it didn't look like we would for awhile. Then he brought out our pistols again and rechecked our competence with them. He gave us the sear mechanism from the carbine, and another piece of emery cloth to carry in the other pocket. This brought more comments from our dinner companions in the mess.

The steel finally began to show some signs of emery polishing after several days. On our third appointment, the sergeant gave us ammunition, and instruction in loading weapons. We advanced to the line in the freezing cold and held the weapon "just so" and there was much more yelling at the top of his voice.

"Don't fire until I say fire, SIR! Stand erect and suck in your gut, SIR!" he barked.

We continued this for hours at a time, freezing in spite of our parkas.

The pistol sure had a lot of kick to it! Our hands became sore as we tried to prevent raising the muzzle each time the pistol was fired. When we missed the target, the sergeant soundly reamed us out, and we began to feel threatened.

"Can't you see the f . . . n' target, SIR?" he shouted.

We had to shoot with each hand, and with both hands, in every position, and then were timed shooting the whole clip as quickly as possible. Trying to get the second clip out of my pocket in a hurry, with a gloved hand, elicited another string of choice words. We did note that the sergeant was finally wearing a jacket, and, on his head, nothing but his campaign hat.

What were doctors learning this for? Then we remembered "Moscow Molly" and her threats, and we returned with renewed resolve. After several weeks we began to get a little cocky when we realized we were getting better at this, but never enough to please the sergeant.

He stopped showing us our targets and we assumed the worst. Dick and I considered telling him that as surgeons, our hands were too delicate to take the abuse of the constant firing of the pistol, but after he reamed us out again we thought better of it and kept quiet. We massaged our hands each night after being on the range, and hoped that we wouldn't develop calluses and hurt our hands.

It was a little easier with the carbine. At least it didn't have the kick of the pistol, and it was a little more natural to shoot a rifle. We had both shot .22s in Boy Scouts, so it seemed more natural. However, we were never good enough to please our instructor. We repeated the drill with the carbine, using various positions and

each hand, as well as rapid fire. Again we had to change the clip as quickly as possible, using a 30-cartridge clip as well as the smaller 15-cartridge clip. The sergeant also showed us how to make the carbine fire like a machine gun, but that was just spraying bullets; we couldn't fire that way for accuracy. There was never any praise from our teacher, and he still had us both scared to death. We even secretly felt that if we did poorly, and missed too often, he might shoot us himself. At last, after many lessons, the time came for us to fire for our ribbons. We were bowled over by his proposal. He called in several of his fellow Marines as observers, and it looked like he was actually proud to put us through the paces, although he tried to hide it. The judges recovered our targets and reviewed them out of our hearing, which gave us no idea how we were doing.

The verdict was a complete surprise. The judges informed us we had both won medals as expert marksmen! We were given small blue and green ribbons to wear on our dress uniforms (which were packed away in storage somewhere). We put them on our shirts and proudly wore them to mess that evening. Eventually, by mail, we were each awarded a medal for both pistol and rifle.

"There's a submarine in the harbor!" someone shouted. Our wind-up telephone was ringing off the hook. Everyone tried to find a place where they could see the harbor. Sure enough, there was a black hulk moving slowly just inside the harbor, and two men on the conning tower were staring at us through their binoculars. There was no flag visible, but a number was painted on the conning tower. It slowly turned away; the men dis-

appeared from the conning tower, and the submarine slipped below the water and disappeared. Was it an American sub? A couple of chiefs said it was Russian, comparing it to pictures and outlines in an official book. We radioed the information, and were informed there were no American subs in the area, and the consensus was that it was a Russian submarine.

This sighting, coupled with Moscow Molly's regular threats on the radio, heightened our fears of attack. Was this the beginning of World War III? Standing there in the wind, staring through binoculars, we were ready to believe anything. We weren't heartened much by learning that our defense was a small task force located around 300 miles to the south. Our weather was so poor, with low clouds and fog over the runway, that no planes could land or take off. The PBYS on Adak were a patrol type, and were not outfitted to carry bombs.

We felt like we were sitting ducks, except for the Marines who were now helmeted as they set up a BAR (Browning Automatic Rifle), a small .30 caliber machine gun mounted on a tripod overlooking the harbor. With sandbags around them, bunker style, they continued to use their binoculars to search the terrain. They were set to repel any forthcoming attack.

Orders were issued to carry our weapons on the job, including the doctors. However, Gus, Dick, and I left our weapons in the desk drawer.

We never saw the submarine again. The next day, however, we were told there was evidence of a landing, with marks from a rubber boat and footprints coming out of the water near the job site. There was also a broken Russian oar left on the beach. This was not too far from where "Sea

Otter" Jones was caging his captured sea otters.

We felt sure a landing party had come ashore that night and waited for daylight to take pictures of the site and equipment, and then left soon after dawn. Looking at the site, it was hard to determine what we were doing. The drills, which looked like oil well drills, were all that could be identified. The drill sites could be mistaken for missile silos, but we thought that was a real stretch. We had to set up an around-the-clock watch thereafter, and target practice became more popular on the rifle range.

Moscow Molly's harangues at night didn't change their tenor. We were still said to be building V-2 rocket-launching platforms aimed at the heartland of Russia, for which we would pay dearly when the Russians ruled the world. She continued to remind us that each one of us would be hung in Red Square, for the entire world to see. Rightly or wrongly, we concluded that they hadn't learned anything from their sneak visit to our project.

As Dick and I struggled with our books about atomic energy, we continued to ponder the responsibility the Navy charged us with—providing medical care for more than a thousand men before and after an atomic bomb was exploded. It was even worse to consider an underground bomb, one that was being tested to see what would happen to the island, its inhabitants and animals, the environment, and perhaps the whole world. . . So many unknowns! That is the purpose of tests. All the talk about the hydrogen bomb, just before our ship sailed, made us wonder if that device would be the subject of our tests.



We had sent for radiation and film badges, and had begun to learn how to use them. We tested them in the x-ray machine and found they worked. These, of course, were no protection; they simply documented the exposure. Excessive exposure killed people, and the only information the dosimeters would provide would be who had received exposure in an excessive amount.

We soon arrived at the correct conclusion. Preventing exposure in the first place was paramount; this meant not only from the bomb, but from the aftermath of the bomb. The bomb had residual material, and it also caused surrounding materials to become radioactive. The half-lives of these materials varied tremendously, from a few minutes to hundreds of years.

Would any place on the island be safe after the explosion? Would exploding the device underground contain the radioactive material, or would it just make more materials radioactive, with many different half-lives? Would radioactive material be confined to the island or would it be spread more widely? How widely?

“The admiral’s coming! The admiral’s coming!” It was like a Chicken Little saying “The sky is falling!” The word spread like wildfire

that a group of visitors and scientists were coming, under the direction of the admiral in charge of the whole project. Great effort was spent preparing for this special inspection. This was not the usual weekly and monthly once-overs to which we were accustomed. This would be an admiral’s inspection.

Except for a few workers out on the site, the rest of us would have to be cleaned up and standing in front of the hangar in dress parade formation. Even we doctors had to be there to welcome the admiral. Muttering and crabbing, we were all there.

The admiral must have ordered the weather, as it was really beautiful that day. The shiny, all silver plane appeared overhead and prepared to land on our single usable east to west runway. I noted the windsock on top of the hangar standing out straight to the north, indicating a strong cross wind from the south.

Our runway was 25-07, oriented almost east and west. (Runways are numbered by their compass heading, minus the last number, which made ours oriented to 250 degrees, and the reciprocal for the opposite direction, minus or plus 180 degrees; in our instance 250 minus 180 equals 070 degrees, thus 25-07.) Our usual wind

was approximately 30 to 50 knots, with gusts to 100 knots. Since we still had no anemometer we had no accurate indication of wind speed and could not provide this information. The pilot lined up with the runway and was soon drifting north toward us on the north side of the runway. Despite making many crabbing corrections, the pilot was unable to keep the plane lined up with the runway. He finally realized he couldn’t get the plane down safely, and applied power for a go-around, and another attempt. His wheels retracted but his climb was slower than he expected, and he was blown so far off the runway course that he was now headed straight for us, standing at parade rest in front of the hangar. We stood there, transfixed as the pilot again tried to climb with the wheels slowly retracting. We were looking directly at the plane’s nose.

I will never forget that silver nose as the pilot struggled for altitude. Luckily all four engines were running at full power. He roared directly overhead, missing the hangar by about 15 feet, with all of us standing there right in front of it. He slowly climbed out to make another try, this time much further out, so that he had time to compensate for the strong cross wind. The plane landed safely. (To be continued.) □

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# Training is Not Always the Solution

CDR Steven E. Linnville, Ph.D., MSC, USN  
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In FY02, the Chief of Naval Operations (CNO) began restructuring career planning for the Sailor into a 5-vector development model to be implemented through Task Force EXCEL. The model spans personal and professional development for enlisted personnel, from recruit to master, and for officers, ensign to captain. Task Force EXCEL (TFE) is also restructuring the Navy's traditional philosophy, "if there is a performance problem, then training is needed." While training is an important Navy mainstay, the CNO expects other variables to be included in an evaluation to determine the necessity of implementing training. To expertly conduct a performance evaluation, the CNO has envisioned a trained team of Human Performance (HP) consultants housed at each Center of Excellence who would investigate interventions other than training.

Human performance is a multi-disciplinary effort (such as, personnel, training, manpower, health, safety, and human factors) to generate and compile information about human capabilities and limitations. HP applies that

information to equipment, systems, software, facilities, procedures, jobs, environments, training, staffing, and personnel management in order to produce safe, comfortable, effective human performance.(1) Human Performance Improvement (HPI) is a systematic analysis of the total composite of these multi-disciplinary elements and their impact on the human component to make recommendations to enhance mission, individual, and team performance. To do this, HPI applies the Performance Improvement Model shown in Figure 1 to conduct an analysis. The model is goal-centered with a set of performances to accomplish the goal(s). An HP consultant identifies the business goal(s), and the desired performances needed to achieve them. The HP consultant compares the actual performance of individuals to the desired performance level in order to identify a performance gap. Then examines the multi-disciplinary factors hampering personnel from achieving the desired performance state in order to make recommendations in changing the impact of these multiple factors. This model was

recently applied to dental laboratory technicians (DT 8752 & 8753) to make recommendations in improving their production.

With combined shortfalls in filling dental technician (DT) billets and in declining enrollment in dental laboratory technician training (particularly advanced prosthetic laboratory technician, DT 8753) at the Tri-Service Dental Technician School (Sheppard Air Force Base, TX), production in creating dental prosthetic fixtures for the Fleet has declined.(2) It has produced an estimated 100,000 backlog in "fixed" restorative treatments.(3) The estimated present annual capacity of the dental laboratory system is approximately 26,000 units annually.

One solution for increasing production was to replace unfilled billets with contractual support at a cost of \$1.2M realized from the loss of 100 DT billets.(4) Unfortunately, the total number of expected contract hires has not been accomplished and were at 75 percent in FY02 and 86 percent in FY03 system wide.(5,6) The difficulty in filling these billets parallels the marked decline of available civilian

dental technicians, because of low starting salaries in the profession.(7)

Another solution to increase production was the potential implementation of a commercial training program over a 7-year period, at two of the area dental laboratories, at an estimated total investment cost of \$2.3M, (of which \$300K was identified for education) with an anticipated return on investment of 269 percent.(3) In January FY02, the Tri-Service Dental Corps Chiefs submitted a proposal to institute commercial training.(8) A working group assigned to evaluate the efficacy of the commercial training program, yielded multiple accolades and presented options to incorporate this commercial training into the current curriculum.(9) Participants in the commercial training at one of the Advanced Dental Laboratories demonstrated producing at least four prosthetic devices in a day compared to the minimum aver-

age of two prosthetic devices per day.(8) However, the Air Force and Army expressed skepticism in utilization of this commercial program particularly as it relates to franchise commitment and long-term expenses. (9)

The authors, as HP consultants assigned to the Naval Medical Education and Training Command (NMETC), Bethesda, MD, were asked by the Navy medical representative to the inter-service training review organization to evaluate the commercial training solution. Using the Performance Improvement Model, the authors determined that the business goal was to improve a dental laboratory technician's production from the minimum two prosthetic devices per day to four per day(9) which could potentially double the dental laboratory system's estimated annual capacity of 26,000 units.(3) The multiple factors examined included the declining enrollment at the Tri-Service Den-

tal Technician School, the curriculum, career-advancement potential, and impact on service member's family. They concluded that prior to implementing any commercial training program, the Tri-Service curriculum needed to be assessed for updated training aids, increased practice opportunities, and potential merger of the DT Navy Enlisted Codes (NECs). Specifically, the recommendations were the following:

Change Training Requirements Inventory objectives from a "guided" training level to a "standard" training level, and requiring instructors to follow the standard and have students repeatedly practice to the standard. Repetitive training to a standard will parallel the commercial training program.(10) Graduates of the program should be informed of desired Fleet production standards (four prosthetic devices/day) and practice achieving that level during training.

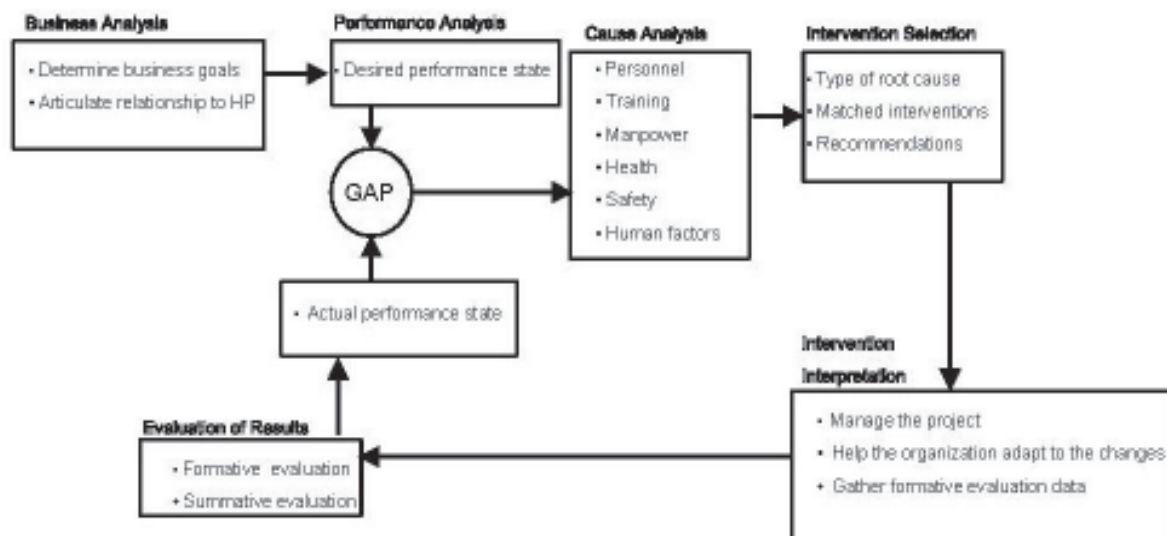


Figure 1. The Performance Improvement Model. Figure adapted from one by Sanders, E. (2002). What is HPI? What makes a Performance Consultant? How can you tell if you already are one? In George M. Piskurich (Ed.), HPI Essentials: A Just-the-Facts, Bottom-Line Primer on Human Performance Improvements, pp. 1-10. ASTD Publications Department, Alexandria, VA.



Merge the Basic (8752) and Advanced (8753) Dental Technician NECs into one, and consolidating the Tri-Service training from two 6-month courses to one 9-month course. This merger would enable students to be productive at remote one- to two-technician dental facilities. The merger of the two curricula would diffuse the negative family impact of an additional permanent change of station (PCS) move which is required to attend advanced classes and assignment of follow-on PCS orders without negotiation.(2)

As part of career development, consider sending dental technicians to 4-week, advanced "just-in-time" training modules in a temporary additional duty (TAD) status specific to the needs of the dental treatment facility (DTF) to which they are assigned. The Army and Air Force currently operate their curriculum in a temporary duty supplemental course concept with the latter service as part of their career development.(2) The advantage in TAD training would close the gap in advanced class attendance, eliminate two PCS moves (estimated cost savings of \$20K per student), and provide a larger pool of comprehensively trained technicians in keeping with Task Force EXCEL advancement.(2) (Currently the advancement opportunities are low for 8753s and non-existent for 8752s.)

The authors agreed that in the short term, the commercial training program offered an opportunity for an immediate increase in productivity. This program is based on repetitive synchronized coordination of media and instrumentation. Its premise is not unlike the methods used in the current Tri-Service training program. In the long term however, the commercial program is costly because it is proprietary. It will require continual

financial resources to maintain specialized training of new instructors, and in maintaining the proprietary equipment.

There is a substantial cost savings with the elimination of PCS moves. Other realized improvements in the quality of life for the Sailors and their families include: an incentive to obtain more advanced training supported by the DTFs; a clearly defined career pathway in the merger of the two NECs with the latter NEC now the "mastery" level in the TFE 5-Vector Model; the potential in filling DT billets and augment enrollment, that ultimately will lead to increased production and timely customer service to the Fleet. These HPI recommendations are a total composite of the multiple elements affecting DTs. If applied as interventions (the lower portion of Figure 1), they could enhance mission and overall Fleet readiness and reduce the performance gap that currently exists. The recommendations were submitted to the Health Care Interservice Training Review Office (HC ITRO) for consideration in a curriculum review planned in September 2003. We will follow-up at a later date assessing performance improvements in this community.(11)

"The moral of this story is that in HPI you should not assume that a performance gap indicates [only] a need for training, in fact, you should try not to assume anything. For HPI, cause analysis is used to determine why the performance gap exists and identify the factors that are contributing to it. This process allows the HPI practitioner to choose the most effective intervention to close the performance gap."(11)

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# One System, One Solution

## Voice Recognition Dictation/Transcription System at Naval Hospital Camp Pendleton

LT Christian Wallis, MSC, USN

Imagine, for a moment, a clinic process where providers come to work in the morning and lift their Compaq iPAQ PDA from its cradle to view their patient load for the day. The provider swiftly moves through patient appointments by diagnosing each patient and then dictating the note directly into the PDA after the appointment is completed. The dictation creates a voice file that is attached to the demographic information for that particular patient. Further, imagine processing this file through a voice recognition server for editing by a transcriptionist, then sending it back to the provider within 24 hours for an electronic signature and subsequent upload into CHCS.

Naval Hospital Camp Pendleton has purchased and developed the first of a two-stage plan for this comprehensive dictation/transcription system. The first stage, currently in progress, is the installation of the main system in the core hospital. The second stage will enable the various branch clinics to access the system from remote locations. Dictaphone is the chosen vendor whose products consist of voice and text servers integrated into our

local area network (LAN); featuring a bi-directional interface with CHCS, and using Compaq iPAQ PDAs as the chosen instrument for voice capture.

### History

The opportunity to re-evaluate our dictation and transcription business practices occurred when our current transcription contracts were being renegotiated. Initial analysis revealed disgruntled physicians using telephones and micro-cassettes to cap-

ture various types of patient information. The transcriptionists would then log in and out of three different legacy systems, on two different computer terminals, to ensure the right information was placed in the right database. To make matters worse, we had been a part of a regional out source transcription contract that didn't have connectivity with any of the three legacy systems. Meanwhile, the Emergency Room was on a completely separate out source transcription contract that



Kathy Phillips (transcriptionist) demonstrates to LT Wallis the ease of use of the new Dictaphone system.

was not connected to any of the legacy systems. We quickly realized why only 30 percent of our providers were utilizing our transcription services. The systems and processes had become too cumbersome and inefficient to be productive.

### **Opportunity/Planning**

Once the initial analysis was complete, we formed a group of “stakeholders” to identify what the goals of a new system would be. The four main goals were to (1) leverage technology to increase productivity; (2) adapt technology to the physician vice adapting the physician to technology; (3) ensure compatibility with our current systems; and (4) ensure the chosen vendor would always stay at least one step ahead of our needs and be able to build for the future. Recognizing that all of our current methods for transcription were counter-productive, we began utilizing the slogan “One System, One Solution.” After interviewing several different vendors, the one company that could meet all of our goals was Dictaphone.

The proposal for the “Dictaphone Solution” to our Executive Steering Committee (ESC) focused around our hospital’s strategic vision and goals. These goals included patient safety, optimization, staff satisfaction, force health/population, and information management. In order to help convince the executive committee of our dictation/transcription solution, we utilized a group of internal subject matter experts called the Decision Support Team (DST) to develop a Business Case Analysis. The result of the DST’s analysis fueled our proposal by projecting a return on investment of 297 percent over a 3-year period. In addition, we also projected our earliest successes would be a 50 percent decrease in provider administrative

time, 50 percent increase in transcription productivity and a 100 percent consult feedback rate in less than 24 hours. The ESC overwhelmingly approved the proposal and has played an important leadership role in promoting the system throughout the command. The strong leadership, coupled with senior physician input, has put us in an optimal position for system deployment.

### **Deployment**

Our multi-disciplinary implementation team consists of a clinical director, physician champion, and the Patient Administration (PAD) and Management Information Departments (MID). The team will guide the hospital through a three-phase implementation plan that will take approximately 6 months to complete. The first phase was the initial iPAQ deployment and “voice go live” of the PDAs to specialty clinics and various superusers. The second phase will allow transcription to leave their legacy system behind for the functionality of a more “Windows based” system during the “text go live.” The third phase will be the installation of the “physician workstation” on the providers’ office PCS, allowing the providers to edit and electronically sign their work. Once the document is electronically signed, the report will be directly uploaded into CHCS.

The iPAQ distribution priority focused on solving consult feedback issues and obtaining clinical buy-in. In order to show immediate gains in both of these areas, we deployed the first batch of PDAs to high volume specialty clinics and various “super-users” throughout the command. Deployment has been gradual to allow a smooth transition in transcription without an interruption of services and ensure each provider is adequately

trained on the proper use of the new PDA. Recent issues have included the development of business practices for the Compaq iPAQ to ensure an optimum amount of memory and battery power is available to handle the daily workload of dictation while ensuring the compatibility of other physician tools such as drug interaction checker and basic Microsoft Outlook features.

### **Physician Buy-in**

It is worth noting, at this point, an interesting aspect to Dictaphone’s voice recognition system, “EXSpeech.” The voice recognition piece utilizes the Dragon engine to convert the voice recordings to text. Approximately 70 percent of the providers will have a recognition rate with a high enough accuracy level to qualify them to use voice recognition. Another 25 percent of providers will have voice recognition that is considered “trainable.” The final 5 percent of voice recordings will never be recognizable and subject to complete transcription. An added feature of this voice recognition product is that providers don’t have to sit in a room for 30 minutes to train the system to recognize their voice. The system gathers voice files over several clinical visits and stores them until there are enough files to automatically run the provider through a “fluency meter” for voice recognition. A successful trip through the fluency meter will result in a document appearing before the transcriptionist for editing vice full transcription. The entire process is transparent to the provider and the recognition rate is increased since the tone of a provider’s voice in the clinic is much different than in a training set.

As stated earlier, one of our goals was to ensure that we partnered with a company that could anticipate our needs for the future. Dictaphone has





**CDR Wayne Inman, orthopedic surgeon and physician champion for the command's Dictaphone project, dictates into his Compaq iPAQ.**

done this by developing electronic coding tools that may be used in conjunction with our new system. Currently, there are two tools available. The first tool is the "GoMD charges" whereby providers will have the opportunity to code patient visits utilizing an electronic "superbill" on the PDA. The other tool, called "ichart Coding," routes transcribed documents over the Web to a coding recognition server. The document is electronically scanned for applicable medical terminology codes and sent back to the hospital with a 95 percent coding accuracy rate. With the rising cost of coding, we see this as a more cost effective solution for the future.

### **"Revolutionary?"**

We would like to say that we were ground-breaking in our search for a better information management solution. Although Naval Hospital Camp Pendleton is the first to purchase the entire Dictaphone package with the Compaq iPAQ as the instrument for voice capture, due credit should be given to our brethren in Army medicine. The Army's \$30 million "AMEDD New Generation Dictation and Transcription" contract with Dictaphone began several years ago and has paved the way for much of the administrative approvals required for the bi-directional interface with CHCS. Naval Hospital Camp

Pendleton continues to track the progress at Madigan Army Medical Center, as the bi-directional interface between CHCS and Dictaphone was first implemented there. Our ultimate vision is to see 100 percent optimization of our Dictaphone system via a triumvirate of bi-directional interfaces: CHCS/Dictaphone/CIS (Clinicomp's Clinical Information System used for inpatients).

### **Success To Date**

With 50 percent of our specialty providers using the new system, they are all pleased and adapting very quickly. Once the word got out that personal PDAs were being deployed as a part of the new transcription system, many clinicians were interested to find out where they were on the pecking order of the iPAQ distribution list. From a change-management perspective, this is a pretty good place to be. We will continue to manage clinical expectations as we gradually phase out our current transcription contracts and phase in the Dictaphone system. The continued deployment of PDAs will eventually reach primary care outpatient clinic notes. The hope is to eventually move to an entirely electronic medical record in CHCS.

The complexity of this project has brought our multi-disciplinary team closer together in a spirit of cooperation. With strong leadership and dogged determination, we remain optimistic as we sail through the waters of change management in our search to liberate our providers from administrative burdens. □

LT Wallis is head, Patient Administration, Naval Hospital Camp Pendleton, CA.

## In Memoriam

*On 29 November, Navy medicine lost another of its World War II heroes, LT Robert Kentner, MSC, USN (Ret.). LT Kentner died at his home in Frederick, MD. He was 86. As a pharmacist's mate on the eve of Pearl Harbor, PhM1c Kentner was assigned to Naval Hospital Cañacao, the Philippines and was there when the Japanese captured Manila. He and his comrades were interned in Manila's notorious Bilibid Prison until he was liberated in February 1945.*

*In the November-December 1987 issue of Navy Medicine, we published an article by Victor Ullman, himself a former Navy hospital corpsman. That article related how Kentner kept a secret journal. Remarkably accurate, it contained death and burial records, dates of arrival and departure of prisoner drafts, prison census figures, rosters of personnel on duty, and floor plans and drawings of the Bilibid Prison compound. Upon his repatriation in April 1945, Kentner personally delivered the journal to the Hospital Corps Archives Unit at BUMED.*

*"The War's Most Incredible Document," first appeared in the 9 February 1946 Liberty magazine. We reprint that article again in its entirety.*

Even on his honeymoon Pharmacist Robert W. Kentner, USN, was not allowed to forget a long procession of his shipmates whose obituaries he had written in shipshape Navy fashion in one of the most incredible documents of the war.

Bob Kentner and his wife, Maureen, both of Buffalo, NY, were having lunch at their Asbury Park, NJ, hotel one day last June when a long-distance call from Chicago came for Kentner.

"Please forgive me, but I had to call you," a woman's voice said. "I begged your mother to tell me your whereabouts. She said you would understand." She stifled a sob. "My brother was in Bilibid Prison with you, and the Navy told me you kept a secret diary and—I must know something about my brother."

She mentioned a name that took Kentner back to the Philippines. It

was the morning of 11 October 1944, when Kentner said good-bye to Arthur and watched him, with nearly 1,800 other prisoners, straggle out of the Bilibid gates for the death ride to Japan.

"Please, Mr. Kentner," the woman pleaded. "My mother is dying. Just a little encouragement might save her. Can you give me any hope?"

This was 4 months before the trickle of information began from the survivors of Jap prison camps. Kentner himself had been out of a naval hospital just 6 weeks after recovering from the privations of 3 years and 2 months of imprisonment.

The call upset him. "What could I tell her?" he asked his wife. "My log shows that Art was one of 91 pharmacists' mates in a draft of 1,784 men that boarded a Jap freighter in Manila Harbor on that October morning. Two days later the ship was sunk in Subic

Bay and there were five survivors. None of them were pharmacist's mates."

Through two naval hospitals, on his honeymoon, and now daily at his Navy duties, Pharmacist Kentner has not been allowed to forget Bilibid Prison. He is besieged by telephone, letter, and personal visits. He is begged for some detail from his "secret diary," anything to provide a glimmer of hope for survival of their loved ones taken prisoner by the Japs so long ago.

Recently, however, with more and more personnel records in the War Department and the Navy Department changed from MISSING IN ACTION to KILLED IN ACTION, relatives want to know how their boys looked before they died. Or did they give Kentner a message before they left for Japan and death? One girl asked, "Did he ever mention my name?"

Kentner tries to remember each name and face out of the grim 3 years, and when he cannot offer a shred of solace, is as unhappy as his visitors. He tends to disregard the fact that nearly every county of every state has at least one family which has been helped by one of the most amazing documents of the war—an undramatic monument to a certain kind of courage.

In the armed forces this document has come to be known as “Kentner’s Log.” Transcribed from the scraps of stolen Japanese paper on which it was typed, the journal fills more than 200 pages of single-spaced typing. It is not a thrilling epic of the war or gruesome story of imprisonment. There are no adjectives in it beyond descriptive qualifications of fact. Terse and purposeful, this piece of writing took 3 years and 2 months to complete, and it was written under the eyes of Japanese guards, yet without their knowledge.

Kentner’s Log contains nothing but names, dates, numbers, and events with such consecutive entries as these:

“10-23-42: 78 men arrived from Cabanatuan, P.I., this date. HARBIN, Earl Charles, ChMachM USN, Ser. No. 271-90-28, died at 2245 this date. Cause of death: intraspinal injury (war injury). Buried in hospital plot, row 3, grave 17. Lt. L.W. King USA reported to this hospital this date from Cabanatuan for the purpose of experimental work in the propagation of yeast.

“10-25-42: Four gallons of yeast prepared and distributed to patients suffering from vitamin B deficiencies.

“10-27-42: SADLER, Edmund F., Pfc, USA, ASN, 19020690, died at 0805 this date. Cause of death: malnutrition. Buried in hospital plot, row 3, grave 18 . . . .”



Robert Kentner (arrow) appears in this Japanese propaganda photo taken in Bilibid. August 1942.

In a number of ways these entries assisted the thousands of families whose loved ones are listed. They derived some solace from the details of the death and relief from the continuing torture of the words: MISSING IN ACTION.

In a more concrete way, families were aided financially by these factual entries. Both the War and Navy Departments accepted the identifications and the fact of death as official for all listed in Kentner’s Log. The families, therefore, were able to obtain the back pay, benefits, insurance and pensions, which could not be paid legally until death was established. The entries also helped many a wife and mother to accept the fact of death. Such as the woman in New York who wrote:

“Can you tell me only if my husband was alive on November 20,

1943? If he was alive on that day it will make me very happy because it was our anniversary and I told our little boy that daddy was thinking of us. We both prayed for him.”

Kentner was able to inform the wife that on 20 November 1943, her husband was in the isolation ward and that the day was one of the greatest in the prison lives of all the emaciated men because the first substantial supplies of Red Cross relief food were distributed. Her husband received a 47-pound food package and the entire camp was filled with a holiday spirit as the men ate their fill for the first time in almost 2 years.

Since Bilibid was designated by the Japs as the major prisoner-of-war hospital in the Philippines, Kentner’s careful entry of admissions from the other prison camps, from Japan-bound drafts, and from the dread





Photo from BUMED Archives

work gangs constitutes an irrefutable record of conditions at these localities for the Americans. Day after day the log is filled with a record of wholesale admissions of patients from the work camps at Los Pinos, at Pasay, at Palawan, and from the road gangs in Tayabas. Shortly after these admissions were recorded, Kentner always was forced to add to his records of death. Some of the prisoners were delivered dead and in sealed caskets.

Kentner's tenacity in keeping his log night after night for 3 years 2 months, with the risk of detection constant, represents a special type of courage. That is a long time to walk under the sword. But Kentner explains it simply:

"I was scared all the time, but I got all the breaks. I did my job, but what's so unusual about that? Every hospital corpsman in that prison did his job. I

was assigned to the personnel office to work for Cliff Condon [Pharmacist Clifford K. Condon, USN, of Vallejo, CA]. That was on 30 May 1942. Cliff told me the Americans wouldn't be back in P.I. for 2 years. I thought he was crazy, but he said we were a hospital in the U.S. Navy and we had to follow orders as we last knew them. One of these orders was that every naval hospital keeps a record of its work. It was his idea, his orders. I did it. That's what I was trained to do."

When Condon was shipped off on a Japan draft, to die in a prison camp on Kyushu on 2 June 1945, Kentner carried on. He knew his punishment, if caught by the Japs, would be nothing less than a long prison term and he might be executed.

"You get used to the danger," he says. "I used to make my notes in my

own shorthand and then type them out at night. You could hear the guards coming, for they all wore metal cleats on their shoes. I'd switch an official Jap report into the typewriter and wait for them to go by. Then I'd start the typing again.

If the Japs hadn't been so stupid, I would never have been able to keep the log. Even so, I was scared all the time until they caught me in April 1944."

From that date until liberation in February 1945, Kentner kept his log under Japanese protection. It happened this way:

Kentner was typing in the personnel office late one night, when suddenly a voice boomed at him from the barred window.

There was a snarl of "*Kuda*," meaning in Japanese "You no-good louse." Kentner recognized the voice as belonging to "Captain Bligh," the name given a sergeant of the guard because he was rough and totally *Kuda*. The Jap had sneaked up to peer into the paneless window.

"I realized he had to go around to the front of the building to get at me," Kentner says, "so I ripped the page of the log out of my typewriter and switched in the phony report. Then I noticed the report was dated about 6 months ago because I hadn't kept it up to date. But it was too late to do anything."

Captain Bligh stormed in, ripped the sheet out, and took Kentner to the guard office.

"Luckily Sato was noncom of the day. He could talk a little English but couldn't read much. He was pretty decent if you oiled him," Kentner says.

"Captain Bligh gave him a long story in Jap, then shoved the report in his face. I thought I was through. But I began to oil Sato. I explained that Lieutenant Nogi, the hospital director

for the Japs, wanted certain reports by 8 A.M., and that meant working at night. While I talked, Sato stared at the report. Then he interrupted me.

"This is a serious violation," he said, which made me certain I was in the soup. "I do not know what punishment will be given. Light bulbs must be conserved. You have used them at night without permission."

"It seems Captain Bligh had accused me of burning the lights, not typing at night. They sort of expected me to type, since I worked in the personnel office. Sato handed back the report. I staggered off and flushed it down a toilet. Next day I was authorized to burn lights at night, and to keep the guards from disturbing me. The Japs also gave me a white arm band which said 'Office Man.' After that, it was a cinch."

The dangers were further eased in July of 1944 when Kentner was named by Commander Thomas H. Hayes, MC, then commanding officer of the hospital as interpreter and liaison with the Japs to relieve Pharmacist Edward F. Haase, whose proficiency in the Japanese language almost caused his death.

"I knew some conversational Japanese and could get along with the guards, but Haase really knew the language. He was so good they sent him along with a draft of prisoners for Japan.

"When Haase left, we lost one of the strongest protections we had against the unpredictable Japs. It's hard to say how many lives were saved by the way he worked the Japs, but it was plenty. When I took over his job the responsibility scared me."

Kentner's Log records on 2 August 1943, that Haase, with Radio Electrician Earl G. Schweizer, USN, and Chief Pharmacist's Mate Abel O. Gomes, USN, were commended by

Major General Xitiro Morimoto, commanding general of the Japanese military prison camps in the Philippines, for their work.

The task assumed by these men required complete disassociation with themselves. They were forced to swallow everything to benefit the prisoners. This they did at a personal cost that cannot be estimated. Kentner was forced to assume the same sacrifices.

His new duties allowed him to expand his log, since he now had all of the administrative reports and communications between the Japs and the Americans at his fingertips.

All of these records were stuffed in a storage space above a noisome toilet outside the personnel office. The Japs never pried into it. When the Yanks took Bilibid on 5 February 1945, Manila was in flames and the prison was threatened. Kentner found an old Filipino Army sack and stuffed it full of his records. He carted this sack across the Pacific and delivered it to the Bureau of Medicine and Surgery on 21 April 1945.

Commander (now Captain) Lea Bennett Sartin, MC, who had been commanding officer of the Bilibid Prison hospital for the first 2 years of its existence, was as amazed at Kentner's Log as any of the Navy men who examined it. Before he was imprisoned by the Japs at Cabanatuan, he had been in daily contact with Kentner, but had had no knowledge of the existence of the log.

"If I had told Dr. Sartin," Kentner explained, "he would have run the risk of terrible punishment. If I'd been caught he would never have lied about the log. He's not that kind of man. He would have admitted knowing about it and tried to make my punishment easier."

Dr. Sartin has approved the authenticity of Kentner's records.

As Dr. Sartin told his men, when the fighting man is captured he is through, but the hospital corpsman's work becomes more taxing. Perhaps it was the same kind of courage that motivated Kentner himself, that kept the hospital corpsmen going. It may have been training. They were organized from the beginning and never relaxed the structure of a naval hospital organization. For instance, throughout Kentner's Log are entries listing promotions of hospital corpsmen following examination for advancement in rating. They held one examination when the Japs gave them an unexpected holiday.

With consistent restraint Kentner records many crises in the prison, but there is one that overshadows all others. It had such explosive possibilities that on 11 November 1943, Commander Hayes, then Senior Medical Officer, expressed the relief of all the prisoners when he ordered Kentner to place in the service records of 37 hospital corpsmen this commendation:

"11-8-43 to 11-11-43: Served as a member of a party of thirty-seven hospital corpsmen ordered by the Japanese to three days detached duty on Corregidor, to take part in the filming of a Japanese movie. Entire group commended at mast for the splendid manner in which they conducted themselves during this trying and undesirable duty. Their behavior served the best interests of all American prisoners of this camp."

For 3 days the camp had been holding its collective breath. The hospital corpsmen had to play the lead parts in this movie titled *Down with the Stars and Stripes*, and there were 62 other Army and Navy men participating, all under command of Lieutenant Talbee of the Army Air Corps.

The Japs threatened reprisals if the men did not co-operate. The movie

was to show the Jap home folks how their armies captured Bataan and Corregidor. The climax of the picture was the scene in which General Jonathan Wainwright surrendered to a Jap colonel. The doubtful pleasure of playing General Wainwright was awarded James F. Bray, Jr., Chief Pharmacist's Mate of Marshall, IL, which Chester K. Fast, Pharmacist's Mate, Second Class, of Haviland, KS, took the role of his aide.

Bray relates that in one scene they were placed in an automobile with the surrender flag out of one window and the American flag hanging out of the other. The car was one that Mrs. Douglas MacArthur had used while she was in the Philippines.

Bray also took part of a major, Forty-fifth USA Infantry, in sequences calculated to serve the Filipino population. These scenes were shot at a downtown Manila studio and depicted an American officer cruelly ordering his batteries to fire into a Filipino barrio. Five hospital corpsmen then were ordered to enact the parts of an American machine-gun battery, and they shot blanks at Japs who banzaied up a slope. Bray's final assignment was to don the full regalia of a three-star American general for close-ups of General Wainwright.

From the Bilibid grapevine Bray later learned that the picture was shown in the Philippines under the title of *The Dawn of Freedom*, while its original title was kept for Japanese home consumption.

The men who participated say there was no trouble, because the whole script was so naively childish that it seemed funny to them. Besides, they were called upon to be braver than

the brave so that the Jap victory would seem even greater in the home propaganda mill.

"We did it because we had to and because the fellows would suffer if there was any trouble," Bray added, "But none of us will ever get Hollywood contracts. We didn't crack our faces once and we spoke our lines as though we were just learning English. I hope General Wainwright never sees those close-ups they took of me in Manila, wearing his three stars and trying to look like a general. He could sue me."

Of the 37 hospital corpsmen whose movie careers began and ended with this picture, only seven survived imprisonment and the two death drafts for Japan. Kentner recorded their names among the dead and missing on 31 December 1944, when the Japanese in Bilibid gave him certain lists to type.

"I had to hold onto myself when I typed," Kentner says. "They were all shipmates. I saw them go. If not for luck, I'd be with them at the bottom of the China Sea. Then I reached Bob Dick's name."

Robert James Dick, Pharmacist's Mate Third Class, of Tonawanda, NY, was a big smiling fellow. He worked like a slave on the wards and made the patients happy by his perpetual joy of living. He was a pal of Kentner's. Dick was nineteen when Manila fell. He had been in the Navy only a year and a half. He was bewildered, and Kentner gave him some of the stability that experience brings. In many messages home Dick told his folks Kentner was steering him.

But Kentner was not able to steer Dick when he was named for the Ja-

pan draft of 11 October 1944. The night before the draft left, he came to Kentner with a penciled note to his mother. Three days later Bob Dick was dead in Subic Bay. Kentner delivered the note to his mother last April.

Bob Dick deserves a special place in the roster of Americans who have given their lives in this war, for he also left a message that was found by the Army. In it he expressed a philosophy that is shared by all his fellow hospital corpsmen. On 21 March 1944, all the prisoners were ordered by the Japs to write their war biographies. This is what Dick wrote:

"I am pharmacist's mate in the Hospital Corps of the United States Navy. I wasn't on Bataan or Corregidor and therefore I did not have the experiences that most of these men have had. Even if I had gone out to the front my duties would have been only to take care of the sick and wounded. I was attached to this unit before the war, during the war, and I have been with this unit ever since we were taken prisoners at Santa Scholastica College. I have only done my part in taking care of the sick and wounded. At times we were short of medicines our task was harder, but we did the best we could and that is all that can be expected. As far as my present state of mind is, all I can say is that I am an American.

Victor Ullman was an ex-pharmacist's mate who had been on the staff of the Hospital Corps Quarterly and assigned to BUMED. Robert Kentner retired from the Navy in 1956 as a lieutenant in the Medical Service Corps. □



## **Book Review**

*A Diminished President: FDR in 1944* by Matthew B. Wills. Ivy House Publishing Group, Raleigh, NC. 191 pages. 2003.

In a review published in the March-April 2003 issue of *Navy Medicine—The Hidden Campaign: FDR's Health and the 1944 Election*, by Dr. Hugh Evans—readers were introduced to President Franklin D. Roosevelt's health history. As a physician, the author provided a unique perspective, from FDR's contraction of polio in 1921 to his seriously deteriorating state before and during the 1944 election, a condition exacerbated by congestive heart failure. Dr. Evans blamed VADM Ross McIntire, Surgeon General of the Navy, FDR, and the media for tricking the American people into thinking the president was healthier than he actually was. Likewise, Evans addressed important issues, such as how to disclose presidential candidates' health without invading their privacy and whether there is a way to reduce some of the high demands placed on the chief executive.

Like Evans, Matthew B. Wills believes that McIntire was responsible for much of the deception. However, instead of focusing on FDR's health history and that deception during the 1944 election campaign, Wills examines FDR's performance as president in that critical year. The author argues that because of his failing health, Roosevelt acted in a manner inconsistent with his previous performance in office, and that he made poor decisions both in domestic and foreign policy that were detrimental to the nation.

As illustrations, Wills focuses on Roosevelt's choice of running mate for his 1944 election, his friendship with Winston Churchill, and his policy toward Poland. He contends that FDR allowed "corrupt city bosses," like Ed Kelley, Ed Flynn, and Bob Hannegan to play a much larger role in the choice of Harry Truman as his running mate than they should have. In so doing, Roosevelt humiliated a long time friend, supporter, and then vice-presidential hopeful, James Byrnes. Likewise, Wills suggests that Roosevelt's treatment of his closest wartime ally, Churchill, was less than friendly in 1944. One example was FDR's failure to secure congressional support for what the British referred to as

"Stage 2"—continued financial aid to Britain after the war, this despite a promise to Churchill to do so.

However, Wills believes that Roosevelt's biggest failure in 1944 was not supporting Poland. Roosevelt and his Secretary of State, Cordell Hull, allowed Stalin to ignore the rightful Polish government and impose a communist regime, thereby condemning Poland to 50 years as a Soviet satellite. According to Wills, Roosevelt, confident in his own foreign policy abilities, chose to act as his own Secretary of State. Wills contends that then Secretary of State Cordell Hull was little more than an aging puppet who was naïve enough not to see Stalin as a tyrant, and that Roosevelt was naïve enough to believe he could wield real influence over the Soviet dictator. Both Hull and Roosevelt failed to heed the warnings of qualified State Department experts who favored the support of the Polish government in exile headquartered in London. Instead, Roosevelt allowed Stalin to install the Soviet-controlled Lublin Committee.

Wills is careful not to paint a picture of an enfeebled man no longer making his own choices. Instead, he argues that FDR was under a great deal of stress trying to win reelection and end the war. His choices were aimed at achieving those ends. What the author suggests is that the means were not always justified, and that Roosevelt's decisions at this late stage were uncharacteristic of his previous performance.

On one hand, this book diminishes FDR's great legacy by showing that he could be fickle, capricious, and egotistical. Yet, by acknowledging these faults, Wills demonstrates the great leader's human frailties: He was doing what he thought was best for the nation he loved and served. Wills argues that despite FDR's deteriorating health and faced by such complex issues during extraordinary times, this great leader's accomplishments are much more than impressive. *A Diminished President: FDR in 1944* is a fascinating read for anyone interested in medicine, World War II, or foreign policy.

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## Navy Medicine ca. 1916



Naval Historical Foundation

Medical personnel with Marines, Port-au-Prince, Haiti.